



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Durable and Home Medical Equipment and Supplies

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1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: August 30, 2016	Scheduled update	FSSA and HPE
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2.0	Policies and procedures as of June 1, 2017 Published: October 3, 2017	Scheduled update	FSSA and DXC
3.0	Policies and procedures as of May 1, 2018 Published: May 7, 2019	<p>Scheduled update</p> <ul style="list-style-type: none"> • Reorganized and edited text as needed for clarity • Incorporated relevant information from the <i>Medical Policy Manual</i> • Modified the note box at the beginning of the module with standard wording • Updated links to the new IHCP website • Updated the Prior Authorization Requirements for Medical Equipment and Supplies section, including: <ul style="list-style-type: none"> – Removed the list of specific items that do not require PA (refer to the Fee Schedule) – Updated criteria for reviewing PA requests – Removed specific instructions for submitting PA requests (refer to the <i>Prior Authorization</i> module) • Clarified information in the Rental Versus Purchase section • Clarified information in the Capped Rental Items section and added that claims for the rental of capped items for more than 15 continuous months are denied • Expanded the information in the Repair and Servicing section, and revised the statement regarding PA requirements for repairs of purchased DME and HME 	FSSA and DXC

		<ul style="list-style-type: none"> Expanded the information in the Replacement section, and clarified requirements for replacement of large DME and HME In the Customized Items section, added that customized items require PA and clarified information about items not considered to be customized Removed the <i>Drug-Related Medical Supplies and Medical Devices</i> section Added the Routine Maintenance section Added an introductory statement about treatment room services in the Orthotic and Prosthetic Devices in the Outpatient Setting section Updated the note regarding LTC providers in the Medical Supplies section In the Coverage and Reimbursement section for augmentative and alternative communication devices, replaced outdated requirements with a cross-reference to the Replacement section In the Automatic External Defibrillators and Wearable Cardioverter Defibrillators section: <ul style="list-style-type: none"> Added information about when AEDs and WCDs are indicated Added PA criteria in the Prior Authorization for the Device and Prior Authorization for AED and WCD Accessories subsections Added exercise and medical criteria in the Indications section for cranial remolding orthosis Added a reference to the Pharmacy Services module in the Diabetic Testing Supplies section Updated Table 1 – Preferred Diabetic Supply List Updated the Continuous Glucose Monitors section and added subsections with authorization criteria Updated the Food Supplements, Nutritional Supplements, and Infant Formulas section, including adding information about LTC facility billing Updated the Gloves section and its subsections, including adding examples of covered and noncovered situations Updated the High-Frequency Chest Oscillation Systems section, including adding PA criteria and removing the names of specific systems 	
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		<ul style="list-style-type: none">• Updated and expanded the Wheelchairs section and its subsections, including:<ul style="list-style-type: none">– Added the Standing Wheelchairs, Nonmotorized Wheelchairs, Power Mobility Devices (PMDs), Power-Operated Vehicles, Wheelchair Accessories – Elevating Leg Rests, and Wheelchair Accessories – Power Tilt and/or Recline Seating System subsections– Updated and expanded the Motorized Wheelchairs section and added subsections for the various power options• Removed <i>Wheelchair Power Seating</i> and <i>Wheelchair Seat Cushions</i> subsections	
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Durable and Home Medical Equipment and Supplies

Note: For updates to coding, coverage, and benefit information, see [IHCP Banner Pages and Bulletins](#) at in.gov/medicaid/providers.

The information in this module applies to durable and home medical equipment and supplies provided under the fee-for-service delivery system. Within the managed care delivery system, individual managed care entities (MCEs) establish their own coverage criteria, prior authorization requirements, billing procedures, and reimbursement methodologies. For durable and home medical equipment and supplies covered under the managed care delivery system, providers must contact the Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise member's MCE or refer to the MCE's provider documentation. MCE contact information and links are included in the [IHCP Quick Reference Guide](#) at in.gov/medicaid/providers.

Introduction

*Indiana Administrative Code 405 IAC 5-19-2 and Indiana Code IC 25-26-21 define **durable medical equipment (DME)** and **home medical equipment (HME)** as equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, and generally is not useful to a member in the absence of illness or injury.*

***Medical supplies** are items that are disposable, nonreusable, and must be replaced on a frequent basis. Providers use medical supplies primarily and customarily to serve a medical purpose, and medical supplies are generally not useful to a person in the absence of an illness or an injury.*

*For lists of procedure codes that the Indiana Health Coverage Programs (IHCP) covers for DME providers (specialty 250) and HME providers (specialty 251), see *Durable and Home Medical Equipment and Supplies Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.*

Documentation Required for Medical Supplies and Equipment

For all medical supplies and equipment, the IHCP requires a written order by a physician, optometrist, or dentist. Verbal orders, communicated by the prescriber to the supplier, are permitted when appropriately documented; however, verbal orders must be followed up with written orders. Suppliers must maintain the written physician's order to support medical necessity during postpayment review. Per 405 IAC 5-25-3(a), a physician's written order and plan of treatment are required as follows: "All Medicaid covered services other than transportation and those services provided by chiropractors, dentists, optometrists, podiatrists, and psychologists certified for private practice require a physician's written order or prescription."

According to 405 IAC 5-19-1(i), "Medical supplies shall be for a specific medical purpose, not incidental or general purpose usage." The IHCP has identified instances when medical supplies were dispensed in excess of medically reasonable and necessary amounts. The following information serves to clarify the IHCP standards for prescribing and dispensing medical supplies, including but not limited to items such as surgical dressings, catheters, and ostomy bags. This information does not eliminate any other IHCP requirements for DME and medical supplies at the time services are rendered.

Documentation Requirements for Prescribers of DME, HME, and Medical Supplies

For all DME and HME, a physician must make the order for the equipment or supply in writing. The written order must be maintained on file for retrospective review purposes.

A physician's signature on an order for DME, HME, or medical supplies authorizes those items to be dispensed to the member. When writing an order for such items, the physician must consider the following questions:

- Are specific instructions, such as frequency of use, directions for use, duration of need, and so forth, listed on the order?
- Is the quantity authorized by the physician medically reasonable and necessary for the patient's medical condition?

The prescriber is also responsible for maintaining documentation in the member's medical record that supports the medical necessity of specific DME, HME, and medical supplies prescribed. To ensure that the appropriate quantity and type of item are dispensed, it is especially important that the written order be detailed. Providing a detailed written order does not eliminate the need for other IHCP requirements in effect at the time services are rendered. The written order for DME, HME, and medical supplies should include, at a minimum, the following information, when applicable:

- Patient's name
- Date ordered
- Physician's signature
- Area of body for use (for items that may be appropriate for multiple sites)
- Type and size of the product
- Quantity intended for use
- Frequency of use (for example, change dressing three times per day)
- Anticipated duration of need
- Indication of refill authorization and the number of refills
 - As needed or PRN (when necessary), refill authorization must be medically necessary and reasonable.
 - The need for long-term use must be documented in the patient's medical record.

<p><i>Note: Orders and physician signatures may be verified retrospectively by the Family and Social Services Administration (FSSA) or the designated contractor.</i></p>

Documentation Requirements for Suppliers of DME, HME, and Medical Supplies

Suppliers are responsible for ensuring that the written order contains the necessary information to complete the order. If the physician's order lacks information necessary to accurately dispense the appropriate, specific DME, HME, and medical supplies, including type or quantity, the supplier must contact the physician's office for written clarification.

Suppliers of DME, HME, and medical supplies must maintain the prescriber's written order in the member's medical record to support medical necessity during postpayment review.

Note: The IHCP requires that Medicaid providers maintain medical records for a period of 7 years, per 405 IAC 1-5-1(b). Services may be subject to recoupment if the physician orders are modified after the service is rendered or if orders are obtained after the provision of service.

Prior Authorization Requirements for Medical Equipment and Supplies

Specific criteria pertaining to prior authorization (PA) for medical supplies, DME, and HME can be found in 405 IAC 5-19. The PA requirements in this document should be used as a guideline for determining procedures requiring PA, but the IAC and any subsequent bulletins are the primary reference.

In accordance with 405 IAC 5-19-6, PA is required for most DME and HME rented or purchased with IHCP funds. To determine whether a particular DME or HME item requires PA, see the Fee Schedules, accessible from the [IHCP Fee Schedules](#) page at [in.gov/medicaid/providers](#). All repairs of purchased DME and HME require PA.

Designated DME, HME, or medical supplies require that a medical clearance form be submitted with the PA request to justify medical necessity. See the [Prior Authorization](#) module for specific procedures and a comprehensive list of items requiring a medical clearance form. In addition, the physician must provide a written, signed prescription describing the item needed, as well as the quantity required, for the member to receive the equipment. Both the rendering provider and the physician ordering the services or equipment must keep appropriate documentation on file.

The IHCP PA contractor reviews requests for DME and HME on a case-by-case basis, using the following criteria:

- The item must be medically necessary, as defined in 405 IAC 5-2-17, for the treatment of an illness or injury, or to improve the member's functional level.
- The item must be adequate for the medical need; however, items with unnecessary convenience or luxury features are not authorized.
- The anticipated period of need, plus the cost of the item, is considered in determining whether the item is approved for rental or purchase. This decision will be made by the PA contractor based on the least expensive option available to meet the member's needs.

For additional prior authorization criteria for specific items, see the appropriate subsection under [Additional Information for Specific DME, HME, and Supplies](#).

In accordance with 405 IAC 5-3-10, PA requests can be submitted (with the provider's personal signature or signature stamp) by the provider types listed in the [Prior Authorization](#) module. PA requests submitted by all other providers – including DME and HME suppliers – must be signed by a physician. If a provider other than those listed in the [Prior Authorization](#) module submits the PA request via the Portal, the requester can upload an attachment documenting that the service or supply is physician-ordered. If a physician signature is not submitted along with the request, the request is suspended for documentation of the physician's order. Failure to submit additional documentation within 30 calendar days of the request results in denial of the request.

Out-of-state suppliers of medical equipment need to meet the criteria established in the [Out-of-State Providers](#) module.

The preceding procedures are intended to streamline the PA process. The FSSA Program Integrity staff evaluates provider profiles and performs retrospective reviews of services no longer requiring PA.

Notes: All services provided to 590 Program members with billed amounts greater than \$500 per procedure require PA.

For residents of nursing facilities and intermediate care facilities for individuals with intellectual disability (ICFs/IID), the IHCP reimburses the DME or HME items that do not require PA only through the approved per diem rate for the facility. Under no circumstances should the facility provider or any other provider bill separately for DME or HME and supply items that are included in the per diem.

Reimbursement for DME, HME, and Medical Supplies

DME and HME reimbursement is based on Medicare fee schedules and classifications of DME.

Reimbursement for medical supplies is equal to the lower of the provider's submitted charges (usual and customary) or the Medicaid calculated allowed amount for the item. The Medicaid calculated allowed amount for an item is the amount on the statewide Fee Schedule, accessible from the [IHCP Fee Schedules](https://in.gov/medicaid/providers) page at in.gov/medicaid/providers. Providers must include their usual and customary charge for each medical supply item when submitting claims for reimbursement. Providers should not use the Medicaid calculated allowed amount for their billed charge unless the Medicaid calculated allowed amount is equal to the amount that the provider charges the general public.

Manually Priced DME, HME, and Supplies

Most Healthcare Common Procedure Coding System (HCPCS) codes specific to particular DME services, equipment, and supplies are reimbursed using the maximum fee pricing methodology. However, several DME and HME service, equipment, and supply HCPCS codes that are nonspecific (with descriptions such as "unspecified," "unclassified," and "miscellaneous") are manually priced. An example of a manually priced HCPCS code is E1399 – *Durable medical equipment, not otherwise specified*.

Reimbursement for DME and HME is based on Medicare's established fee schedule, if available. For codes for which Medicare does not have an established rate and the procedure code remains manually priced, a rate may be established using acquisition cost information. Reimbursement is 75% of the manufacturer's suggested retail price (MSRP). This methodology applies to all fee-for-service (FFS) claims, including Medicare crossover and Medicare Replacement Plan claims. Providers are required to submit documentation of the MSRP with their claims for these codes. See *Procedure Codes that Require Attachments*, accessible from the [Code Sets](https://in.gov/medicaid/providers) page at in.gov/medicaid/providers.

The following are considered acceptable documentation of the MSRP:

- Manufacturer's invoice showing MSRP, suggested retail price, or retail price
- Quote from the manufacturer showing the MSRP, suggested retail price, or retail price
- Manufacturer's catalog page showing MSRP, suggested retail price, or retail price (the publication date of the catalog must clearly show on the documentation)
- MSRP pricing from the manufacturer's website (the manufacturer's web address must be visible on printed documentation from its website)

Documentation of MSRP must clearly come from the manufacturer of the DME or supply item. Claims on which the provider has handwritten the MSRP or modified the MSRP documentation will be denied with EOB 6169 – *The MSRP/cost invoice submitted with the claim is not acceptable for adjudication. The provider can resubmit the claim with proper documentation.*

If billing for an item that has no MSRP, the provider should submit a cost invoice with the following notation: **“MSRP is not available for the product billed.”** Manually priced medical supply and DME procedure codes that have no MSRP will be reimbursed at the provider’s cost plus 20%, in accordance with 405 IAC 5-19-3(c) and 405 IAC 5-19-1(k).

Note: A cost invoice is an itemized bill issued directly from the supplier to the provider, listing the goods supplied and stating the amount of money due to the supplier. If the cost invoice contains more than one item, providers must identify on each attachment which item corresponds to the procedure code and amount identified on the claim.

Providers that create or manufacture custom-molded items specific to an individual member’s needs, such as a custom-molded seating system produced in house, must submit a cost invoice for processing the claim. The item should be identified as “custom” in the description field on the attached invoice.

The documentation submitted with each claim may be monitored or subject to a postpayment review; therefore, the MSRP documentation provided from the manufacturer must match the manufacturer’s cost invoice. Providers must not bill more than their usual and customary charge for any item.

When providers request PA for miscellaneous services, they must include an itemized list of materials in the PA request. For any item providers bill using a miscellaneous code, they must identify a specific number of units for billing purposes and claim adjudication.

Coverage and Billing for DME, HME, and Medical Supplies

The following sections provide general IHCP coverage and billing information for FFS claims for DME, HME, and medical supplies. Providers should bill all DME, HME, and medical supplies on the professional claim (CMS-1500 claim form, 837P electronic transaction, or Portal professional claim) with certain exceptions for pharmacy providers, as described in the [Pharmacy Services](#) module.

Note: For Hoosier Healthwise Package C, the IHCP covers medical supplies and equipment, including prosthetic devices, implants, and hearing aids, when medically necessary. Pursuant to 405 IAC 13-5-1, the benefit limit on DME for Package C members is a maximum benefit of \$2,000 per year, or \$5,000 per lifetime. This benefit limit does not include eyeglasses or medical supplies. Members can purchase or rent the equipment, depending on which is more cost-efficient.

The IHCP does not reimburse claims for medical supplies, nonmedical supplies, or routine DME and HME items for members residing in long-term care (LTC) facilities, including nursing facilities, ICFs/IID, and community residential facilities for the developmentally disabled (CRFs/DD). The IHCP policy stipulates that providers cannot bill the IHCP directly for medical supplies, nonmedical supplies, or routine DME or HME items provided to an IHCP member residing in an LTC facility. This policy also pertains to food supplements, nutritional supplements, and infant formulas (except for medically necessary infant formula, as outlined in the [Food Supplements, Nutritional Supplements, and Infant Formulas](#) section). The facility *per diem* rate includes the costs for these services, and the medical supplier or DME or HME company should bill the LTC facility directly for such services. For a list of DME and medical supply HCPCS codes included in the LTC facility *per diem* rate, see the *LTC Per Diem Table*, accessible from the [Long Term Care DME Per Diem Table](#) page at in.gov/medicaid/providers. Providers that bill the IHCP using HCPCS codes for medical supplies, nonmedical supplies, or routine DME items for members residing in LTC facilities receive a denial with EOB code 2034 – *Medical and non-medical supplies and routine DME items are covered in the per diem rate paid to the long term care facility and may not be billed separately to the IHCP*. For further information, see 405 IAC 5-13-3 and 405 IAC 5-31-4.

All durable and disposable items and medical supplies necessary for the effective performance of a patient’s dialysis are included in the composite rate for renal dialysis; therefore, these items should not be billed separately. See the [Renal Dialysis Services](#) module for details.

Rental Versus Purchase

Providers should base their decision to rent or purchase DME or HME on the least expensive option available for the anticipated period of need.

In accordance with 405 IAC 5-19-8, DME or HME purchased with IHCP funds becomes the property of the FSSA. Providers must notify the local county office of the FSSA Division of Family Resources (DFR) to make arrangements to return the equipment when a member no longer needs it.

For DME and HME with capped rental periods, the IHCP considers the equipment purchased after a member reaches the end of the capped rental period. See the [Capped Rental Items](#) section for more information.

For items that the FSSA has identified as requiring frequent or substantial servicing, reimbursement is limited to rentals only and not for a purchase of the item. See the [Items Requiring Frequent or Substantial Servicing](#) section for more information.

The IHCP makes no payment for rental for any month the member is in an institution that does not qualify as his or her home or is outside the United States for an entire month. However, if the member is at home on at least 1 day of a rental month, the IHCP may make payment for the entire rental month. Similarly, if a member returns an item of rental equipment to the supplier before the end of a payment month, the IHCP may make payment for the entire rental month.

Items Requiring Frequent or Substantial Servicing

For items requiring frequent or substantial servicing, the IHCP reimburses providers for rental payments only, as long as the equipment is deemed medically necessary. The IHCP denies claims for the purchase of these items. As noted in 405 IAC 5-19-4, repair of rental items is the responsibility of the rental provider.

For a list of equipment and supplies requiring frequent or substantial servicing (available on a rental basis only), see the *Procedure Codes for Equipment and Supplies Classified by the IHCP as Requiring Frequent and Substantial Servicing* table in *Durable and Home Medical Equipment and Supplies Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers. The IHCP denies these codes if providers bill them as a purchase.

Capped Rental Items

The IHCP limits certain DME and HME items to 15 months of continuous rental. The IHCP defines continuous rental as rental without an interruption lasting more than 60 days. A change in provider **does not** constitute an interruption in the rental period. For applicable procedure codes, see the *Procedure Codes for DME/HME Capped Rental Items* table in *Durable and Home Medical Equipment and Supplies Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

The IHCP handles claims submitted for these capped rental items in the following manner:

- The allowed charge is the lower of the IHCP rental fee schedule amount or the actual submitted charge.
- The IHCP pays claims for the rental of these items until the number of rental payments made to date reaches the capped rental number of 15 months.
- Claims for rental of these items for more than 15 continuous months are denied.
- The IHCP evaluates requests for approval of these items for documentation of long-term need. In long-term situations, the IHCP may make a decision to purchase the item.

The use of a piece of equipment during a rental period may be interrupted; however, if the patient resumes use of the equipment within 60 days of the last payment, the original 15-month period remains active. If the interruption exceeds the 60-day period, and the interruption reasons are justified, providers must submit a new PA request to begin a new 15-month rental period. The reason for the greater-than-60-day break in the rental period must be documented on the new PA request. Justification for a break in the rental period more than 60 days may include the following:

- Change in medical necessity
- Hospitalization
- Nursing facility stay

Unless the IHCP receives a new PA request justifying the new rental period, the original 15-month period remains active. If a member becomes inactive for a period of more than 60 days, the IHCP requires a new PA to resume services.

Capped rental items are also subject to replacement or servicing when certain criteria are met. The IHCP does not authorize replacement of capped rental items more often than once every 5 years per member, unless there is a change in the member's medical needs, documented in writing, significant enough to warrant a different type of equipment.

During the 15-month capped rental period, the equipment supplier must supply and service the item for as long as the member continues to need it, at no additional charge to the IHCP. At the end of the 15-month rental period, the IHCP considers the DME/HME equipment purchased, and, in accordance with *405 IAC 5-19-8*, the equipment becomes the property of the FSSA.

Subject to PA parameters, for repairs not covered by warranty, the IHCP does not reimburse more frequently than 6 months after the 15th month and every 6 months thereafter, for as long as the equipment is medically necessary.

Used DME Not Reimbursed by Medicaid

The IHCP does not reimburse for used DME, except for the following:

- A4638 – *Replacement battery for patient-owned ear pulse generator, each*
- A7046 – *Water chamber for humidifier, used with positive airway pressure device, replacement, each*

A new item placed with a member initially as a rental item will be considered a new item by the FSSA at the time of purchase. A used DME item placed with a member initially as a rental item will be replaced by the supplier with a new item before being purchased by the FSSA.

Repair and Replacement

Provisions related to the repair of purchased DME or HME and replacement of DME or HME items are outlined in *405 IAC 5-19-4* and *405 IAC 5-19-5*.

Repair and Servicing

The IHCP reimburses for labor costs associated with the repair and servicing of DME or HME. All repairs of purchased DME or HME require PA.

Repairs of prosthetic and orthotic devices, hearing aids, and augmentative communication devices should be billed using the appropriate repair codes for those devices. For all other DME or HME, providers should bill labor costs associated with servicing and repairs using HCPCS code K0739 – *Repair or nonroutine service for durable medical equipment other than oxygen equipment requiring the skill of a technician*,

labor component, per 15 minutes. Providers must attach a materials-and-labor itemization to the claim when submitting it for payment.

The IHCP will not pay for labor for the repair of DME or HME under the following circumstances:

- The IHCP does not pay for repair of equipment still under warranty.
- The IHCP does not authorize payment for repair necessitated by member misuse or abuse, whether intentional or unintentional. The provider must obtain documentation from the member stating that the member understands the service is not covered by IHCP and the member will assume responsibility for the repairs.
- The IHCP does not cover payment for maintenance charges of properly functioning equipment.
- For rental equipment, repairs are the responsibility of the rental provider.
- For DME or HME included in an LTC facility's *per diem* rate, repair costs are also not separately reimbursable.

In addition, the IHCP reimburses for tasks considered to be labor or nonroutine servicing of DME or HME. The IHCP will not reimburse for the following types of services:

- Evaluation of a member for a wheelchair or seating system
- Patient education in the use and care of DME or HME
- Measurement of recipient for DME or HME
- Initial assembly of DME or HME

Replacement

The IHCP reimburses for the replacement of medically necessary DME or HME under the following circumstances:

- **Irreparable damage or wear:** The IHCP does not authorize replacement of large DME or HME items (such as custom/special wheelchairs, hospital beds, and lifts) more than once every 5 years per member, unless there is a change in the member's medical needs.
- **Change in the member's condition that requires a change in equipment:** These changes must be documented by the member's physician, and a request must be sent to the PA contractor demonstrating a significant change warranting new equipment.
- **Loss of the item from theft, fire, or natural disaster:**
 - If the equipment being replaced does not require PA and does not have a limit restriction, the provider may directly bill for the item. The provider should maintain documentation in the member's records to support the reason for replacement. This documentation would be subject to post-payment review.
 - If the item requires PA, the provider must submit a new PA request for the item, including an explanation that the item was lost due to theft, fire, or natural disaster. The provider should maintain documentation in his or her records to support the reason for replacement. This documentation is subject to post-payment review.
 - If the item has a limit restriction, whether or not the DME item requires PA, the provider should submit a PA request for a replacement item with an explanation that the original item was lost due to theft, fire, or natural disaster. The provider should maintain documentation in the member's records to support the reason for replacement. This documentation would be subject to post-payment review.

Customized Items

The IHCP defines custom equipment as equipment uniquely constructed or substantially modified to meet the specific needs of an individual patient. For example, the IHCP would consider a customized wheelchair, billed using code E1399, as a customized item. Customized items require prior authorization.

Due to the unique aspects, providers cannot group these items with similar items for purposes of payment. The costs and charges for construction of the item can vary widely from one patient to another. Suppliers must submit documentation of the costs of the item, including the cost of labor and types of materials used in customizing the item. They must attach a materials and labor itemization and a manufacturer's cost invoice to the claim when submitted for payment. The IHCP reviews each item on the invoice when calculating the reimbursement amount for all customized items. The IHCP reimburses the materials needed for repair at 20% above the manufacturer's cost to the provider.

The following are examples of items that are **not** considered customized items:

- Items that are individually constructed but that have standard costs and charges and can be billed using existing HCPCS codes
- A wheelchair that is ordered in individual parts from one or multiple manufacturers and assembled by a supplier
- A wheelchair that is ordered from a manufacturer that makes available special features, modifications, or components

Modifications to DME

The IHCP may make additional payment for modifications to DME. Examples of modifications to wheelchairs after their assembly include attachments to convert a wheelchair to a one-arm drive, brake extensions, wheelchair hand rims, and antitipping devices.

Routine Maintenance

Payment for routine maintenance of properly functioning equipment is not covered by the IHCP. Routine maintenance includes services – such as testing, cleaning, regulating, and checking equipment – that do not require a technician's skill.

Orthotic and Prosthetic Devices in the Outpatient Setting

Treatment room services are reimbursed at a flat rate that includes most drugs, injections, and supplies. However, the IHCP allows separate reimbursement for specific orthotic and prosthetic codes when rendered in conjunction with treatment-room services and billed with revenue code 274 – *Medical/Surgical Supplies and Devices-Prosthetic/Orthotic Devices* on the outpatient claim. These codes are not separately reimbursable when services are provided on the same day as a surgical service.

For the list of applicable orthotic and prosthetic codes, see *Revenue Codes Linked to Specific Procedure Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers. For additional information about outpatient billing, see the [Outpatient Facility Services](#) module.

Medical Supplies

The IHCP covers some, but not all, medical supplies. To the extent that the IHCP covers a medical supply item, it is a *reimbursable* service only when medically necessary. A physician or a dentist must prescribe all medical supplies and must document the need for such items. Covered medical supplies include, but are not limited to, antiseptics and solutions, bandages and dressing supplies, gauze pads, catheters, incontinence supplies, irrigation supplies, diabetic supplies, ostomy supplies, and respiratory and tracheotomy supplies.

The IHCP does not reimburse for medical supplies provided in quantities greater than a 1-month supply for each calendar month, except when the manufacturer packages those supplies only in larger quantities or when the member is a Medicare beneficiary and Medicare allows reimbursement for a larger quantity. Medical supplies must be for a specific medical purpose, not for incidental or general-purpose usage.

*Note: LTC providers (nursing facilities, group homes, ICFs/IID) must **always** include medical supplies as part of their nursing facility per diem. This requirement applies to all covered medical supplies that are included in the LTC provider's per diem rate (see the LTC Per Diem Table, accessible from the [Long Term Care DME Per Diem Table](#) page at [in.gov/medicaid/providers](#)), even if the LTC facility does not include the cost of medical supplies in its cost report. Under no circumstances should a pharmacy, LTC facility, or any other provider separately bill such supplies to the IHCP.*

The IHCP requires providers to submit claims for medical supplies on the professional claim (CMS-1500 claim form or electronic equivalent), using HCPCS procedure codes. Providers should send all claims for medical supplies to DXC. The IHCP denies all claims for medical supplies submitted on the pharmacy claim type, using NDCs, Health Related Item (HRI) codes, Universal Package Codes (UPCs), or Product Identification Numbers (PINs).

Covered sterile water products are billable with a National Drug Code (NDC) on the pharmacy claim form, which is located on the OptumRx website, accessible through the OptumRx link on the [Pharmacy Services](#) page at [in.gov/medicaid/providers](#). All covered sterile water products, with the exception of those required for compounded prescriptions, are included in the nursing home *per diem* and are, therefore, not separately reimbursable for LTC claims.

Additional Information for Specific DME, HME, and Supplies

The following sections contain special billing, coding, and coverage information for select DME, HME, and medical supplies. For information about implantable DME, see the [Surgical Services](#) module.

Augmentative and Alternative Communication Devices

An augmentative and alternative communication (AAC) device is a device (electronic or nonelectronic) or system that compensates for the loss or impairment of speech function due to a congenital condition, an acquired disability, or a progressive neurological disease. The term includes only equipment used for communication.

The IHCP reimburses for an AAC device, with prior authorization, if a medical doctor or a doctor of osteopathy orders the device in writing.

Prior Authorization

The IHCP requires PA for an AAC device. Requesting practitioners must include medical necessity documentation within, or attached to, the PA request. As part of the PA request, providers must submit a speech-language pathologist's clinical evaluation, substantiating the medical necessity for the communication device.

The IHCP grants authorization for an AAC device only when the documentation presented substantiates all the following:

- The member has demonstrated sufficient mental and physical capabilities to benefit from the use of the system.
- In the absence of a communication device, the member cannot effectively make himself or herself understood by others in his or her communication environment.
- The provider reasonably expects that the member's medical condition will necessitate use of the device for at least 2 years.
- The device will be used to compensate for the loss or impairment of communication function.

In addition, the request must include documentation that identifies all communication devices that would meet the member's communication needs – taking into account the physical and cognitive strengths and weaknesses of the member and the member's communication environment – and recommends the least expensive communication device.

Coverage and Reimbursement

The IHCP determines whether to rent or purchase an approved AAC device based on the least expensive option to meet the member's needs. The IHCP does not deny any AAC device to an eligible member solely because it is not available for rental.

The IHCP does not require a trial period for AAC devices, but the speech-language pathologist who conducts the AAC evaluation may recommend a trial period. The IHCP approves PA for rental of an AAC device for a trial use period when the speech-language pathologist prepares a request that includes the following information:

- Duration of the trial period
- Examination of the AAC device during the trial period, including all the necessary components, such as mounting device, software, and switches or access control mechanism
- Identification of the AAC services provider that will assist the member during the trial period
- Identification of the AAC services provider that will assess the trial period
- Evaluation criteria specific to the member, used to determine the success or failure of the trial period
- Extension of trial periods and provision of different AAC devices when requested by the speech-language pathologist responsible for evaluating the trial use period

The IHCP does not authorize replacement of an AAC device more often than once every 5 years per member, except as described in the [Replacement](#) section.

Subject to PA, the IHCP covers rehabilitation engineering service necessary to mount or make adjustments to an AAC device. The IHCP also covers speech therapy services as medically necessary to aid the member in the effective use of a communication device, subject to *405 IAC 5-19* and *405 IAC 5-22*.

Automatic External Defibrillators and Wearable Cardioverter Defibrillators

The IHCP covers two types of automatic external defibrillators (AEDs) for individual use:

- The stand-alone model (referred to simply as an AED), billed with HCPCS code E0617 – *External defibrillator with integrated electrocardiogram analysis*
- The wearable cardioverter defibrillator (WCD), billed with HCPCS code K0606 – *Automatic external defibrillator, with integrated electrocardiogram analysis, garment type*

These devices are similar to a manual defibrillator, except that they detect and analyze heart rhythms automatically. AEDs and WCDs are indicated for members who normally are candidates for an implanted cardioverter defibrillator (ICD), but for whom ICDs are contraindicated or need to be removed.

Various manufacturers make the AED and WCD devices. Each device uses a battery pack and electrode defibrillator pads, and the initial supplies are usually included with the device. The WCD consists of a vest-like or garment-like device worn under a patient's clothing that holds a monitor, electrodes, a battery, and a small alarm module. Nonwearable components include a battery charger, a computer modem, a modem cable, a computer cable, a WCDNET data storage and retrieval system, and the diagnostic tester. Additional components included with the WCD are a second battery to be used when the first is charging and an extra garment for use when the first is being cleaned.

Both the AED and the WCD are capped rental items (see the [Capped Rental Items](#) section). The IHCP will not purchase both an AED and a WCD for the same member, nor rent an AED and a WCD simultaneously for the same member.

Prior Authorization for the Device

Prior authorization is required for the AED and the WCD, using the same PA criteria.

Members must either meet **both** criteria A and B **or** meet criterion C.

1. The member has one of the following conditions:
 - A documented episode of cardiac arrest due to ventricular fibrillation (VF), not due to a transient or reversible cause¹
 - A sustained (lasting 30 seconds or longer) ventricular tachyarrhythmia, either spontaneous or induced during an electrophysiologic (EP) study, not associated with acute myocardial infarction (MI)² and not due to a transient or reversible cause
 - Familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhythmias, such as long QT syndrome (LQTS), hypertrophic cardiomyopathy, Brugada syndrome, arrhythmogenic right ventricular cardiomyopathy/dysplasia, and familial dilated cardiomyopathy
 - Coronary artery disease with a documented prior MI, with a measured left ventricular ejection fraction (LVEF)² less than or equal to 0.35, and inducible, sustained VT or VF during an EP study
To meet this criterion, **both (a) and (b)** below must occur:
The MI must have occurred more than 4 weeks prior to the external defibrillator prescription
The EP test must have been performed more than 4 weeks after the qualifying MI.
 - A documented prior MI and a measured LVEF less than or equal to 0.30
Patients must not have any of the following:
 - New York Heart Association (NYHA) class IV
 - Cardiogenic shock or symptomatic hypotension while in a stable baseline rhythm

¹ Transient or reversible causes include conditions such as drug toxicity, severe hypoxia, acidosis, hypocalcemia, hyperkalemia, systemic infections, and myocarditis (not all-inclusive).

² MIs must be documented by elevated cardiac enzymes or Q-waves on an electrocardiogram. Ejection fractions must be measured by angiography, radionuclide scanning, or electrocardiography.

- Had a coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty PTCA within the past three months
 - Had an enzyme-positive MI within the past month
 - Clinical symptoms or findings that would make them candidates for coronary revascularization
 - Irreversible brain damage from preexisting cerebral disease
 - Any disease other than cardiac disease (for example, cancer, uremia, liver failure) associated with a likelihood of survival of less than one year
 - Nonischemic dilated cardiomyopathy with measured LVEF less than or equal to 35% of at least 3–9 months duration with NYHA class II or III while on maximally tolerated guideline-directed medical therapy.
2. Implantation surgery is contraindicated.
 3. A previously implanted defibrillator now requires removal.

PA requests for defibrillators for other indications will be denied as not medically necessary.

Prior Authorization for AED and WCD Accessories

The IHCP bases PA criteria for accessories on the estimated average life expectancies of the accessories. Both the AED and the WCD use replacement batteries and replacement electrodes. In addition, the WCD also uses a replacement garment.

PA criteria for each accessory follows:

- For replacement batteries:
 - The member must currently be renting or have purchased an AED or WCD.
 - The battery being replaced must be at least 11 months old or completely discharged.
- For replacement electrodes:
 - The member must currently rent or have purchased an AED or the WCD with integrated ECG analysis, garment type.
 - The electrodes being replaced must have been used for at least 22 months, or it must be proven that the equipment is broken or damaged beyond repair.
- For replacement garment (only for WCD):
 - The member must currently rent or have purchased a WCD with integrated ECG analysis, garment type.
 - The garment must be damaged or worn beyond repair and must have been in use at least 5 months.

Casting Supplies

The IHCP allows reimbursement for cast supplies in conjunction with the initial fracture care service. The IHCP also allows cast supplies when billed in conjunction with the application of a cast, strap, or splint, when billing Current Procedural Terminology (CPT^{®3}) codes 29000 through 29799, when applied initially, without restorative fracture care, or when applied as a replacement when restorative care has been previously provided.

³ CPT is copyright 2018 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

Continuous Passive Motion Device

PA is not required for the continuous passive motion (CPM) device. Providers should bill for the CPM device using the appropriate HCPCS procedure code along with modifier RR:

- E0935 – *Continuous passive motion exercise device for use on knee only*
- E0936 – *Continuous passive motion exercise device for use other than knee*

One unit of service equals 1 day.

Cranial Remolding Orthosis

The IHCP provides coverage, with prior authorization, for cranial remolding orthosis (HCPCS code S1040) for members aged 4 months to 24 months with benign positional plagiocephaly, plagiocephaly with torticollis, brachycephaly, dolichocephaly, or scaphocephaly due to factors such as in utero or intra partum molding, premature or multiple births, and supine positioning.

A pediatrician, general surgeon with a specialty in pediatrics, pediatric surgeon, craniofacial surgeon, or craniofacial anomalies team member must sign the prescription for the cranial remolding orthosis. The prescribing physician must document the medical necessity and prior authorization criteria in the patient's chart.

Indications

The IHCP considers approval for the cranial remolding orthosis when the following criteria are met:

- The member is between 4 month and 24 months of age.
- The provider submits documentation showing that the member received a minimum of a 2-month trial of aggressive repositioning and stretching exercises recommended by the American Academy of Pediatrics and has failed to improve. Exercise should include at least four of the following activities:
 - Alternating back and side sleeping
 - Supervising “tummy time”
 - Rearranging the crib relative to the primary light source
 - Limiting time spent in a supine position
 - Limiting time in strollers, carriers, and swings
 - Rotating activity
 - Exercising neck motion
- The member meets one of the following medical criteria:
 - Moderate to severe positional plagiocephaly, with or without torticollis, documented by an anthropometric asymmetry greater than 6 mm in the measurement of the cranial base, cranial vault, or orbitotragial depth
 - Brachycephaly documented by a cephalic index two standard deviations above or below the mean (approximately 78%)
 - Scaphocephaly or dolichocephaly in premature or breech infants with a cephalic index significantly less than 78%
 - Asymmetry or the need for further correction after surgical treatment of craniosynostosis, considered on a case-by-case basis
 - Moderate to severe residual plagiocephaly after surgical correction of plagiocephaly
 - The pediatric neurosurgeon or craniofacial surgeon who performed the corrective procedure must provide documentation of medical necessity

The IHCP considers treatment for approval on a case-by-case basis for members aged 12 months to 24 months with severe plagiocephaly and who are considered to have a reasonable likelihood of continued skull growth. A pediatric neurosurgeon, craniofacial surgeon, or craniofacial anomalies team member must provide documentation of medical necessity. The member must have a documented trial of repositioning and stretching exercises, as described previously, to be considered for approval.

Contraindications

The following are contraindications to receiving cranial remolding orthosis:

- Members older than 24 months of age
- Unmanaged hydrocephalus
- Craniosynostosis

Custom Tracheostomy Tubes

A custom tracheostomy tube is a device on which the manufacturer is required to make substantive customization or modification to meet a specific member's medical needs. The IHCP covers custom tracheostomy tubes, with prior authorization. Authorization of custom tracheostomy tubes requires clinical documentation supporting the medical appropriateness and a statement from the prescribing practitioner explaining why a standard or off-the-shelf tracheostomy tube will not meet the member's medical needs.

Custom tracheostomy tubes are billed with HCPCS code S8189 – *Tracheostomy supply, not otherwise classified*. A cost invoice must be submitted with the claim.

Diabetic Testing Supplies

Reimbursement is not available for medical supplies, including diabetic supplies, dispensed in quantities greater than a 1-month supply for each calendar month, except when packaged by the manufacturer only in larger quantities or when the member is a Medicare beneficiary and Medicare allows reimbursement for a larger quantity.

The IHCP accepts Medicare crossover claims for diabetic test strip procedure codes with dates of service that span 90 days. For affected procedure codes, see *Durable and Home Medical Equipment and Supplies Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

HCPCS procedure codes for test strips and lancets have maximum quantity limitations as follows:

- A4253 – *Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips*
 - Providers are permitted to bill up to four units of A4253 (200 strips) per month.
 - Additional units of A4253 will be denied unless PA is obtained.
- A4259 – *Lancets, per box of 100*
 - Providers are permitted to bill up to two units of A4259 (200 lancets) per month.
 - Additional units of A4259 will be denied unless PA is obtained.

The following PA criteria are required for additional units of A4253 or A4259:

- A signed statement of medical necessity
- A clear medical recommendation of the number of additional units required to meet the patient's medical need
- A hemoglobin A1C test dated within 90 days prior to the request for additional units

Note: Pharmacy providers follow billing instructions in the [Pharmacy Services](#) module.

Preferred Diabetic Supply List (Monitors and Test Strips)

The FSSA chose Abbott Diabetes Care, Roche Diagnostics, and Trividia Health as preferred vendors to supply blood glucose monitors and diabetic test strips for all Indiana Medicaid members.

The following Preferred Diabetic Supply List (PDSL), Table 1, is for blood glucose monitors and test strips billed on professional claims (*CMS-1500* claim form or electronic equivalent), including all batch and professional Medicare crossover claims. This information does not apply to other diabetic supplies, including but not limited to syringes, pen needles, lancets, lancing devices, alcohol swabs, control solutions, ketone strips, or blood ketone test strips.

Table 1 – Preferred Diabetic Supply List

Blood Glucose Monitor	Corresponding Test Strip
FreeStyle InsuLinx Meter	FreeStyle InsuLinx Test Strips
FreeStyle Lite Meter	FreeStyle Lite Test Strips
FreeStyle Freedom Lite Meter	FreeStyle Lite Test Strips
Accu-Chek Aviva	Accu-Chek Aviva Plus Test Strips
Accu-Chek Aviva Plus	Accu-Chek Aviva Plus Test Strips
Accu-Chek Nano SmartView	Accu-Chek SmartView Test Strips
Accu-Chek Guide Meter	Accu-Chek Guide Test Strips
TRUE METRIX Self-Monitoring Blood Glucose System (with or without Bluetooth)	TRUE METRIX Test Strips

Blood glucose monitors and diabetic test strips not included on the PDSL require PA. The FSSA advises prescribers to prescribe only the products listed on the PDSL, which eliminates the need to obtain prior authorization for the product. Prescribers may also write the prescription in a generic version (“Blood glucose monitor and/or diabetic test strips”) to allow the pharmacy or DME provider to dispense the blood glucose monitor or diabetic test strip product included on the PDSL. If a member has a unique circumstance that requires the use of a product not listed on the PDSL, the prescriber must obtain prior authorization. Prior authorization will be granted for members based on medical necessity.

Claims for procedure codes E0607 – *Home blood glucose monitor* and A4253 – *Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips* require the 11-digit National Drug Code (NDC) or NDC and modifier, depending on the vendor of the product being dispensed. If the NDC is missing, invalid, not in the proper format, or does not correspond with the procedure code and modifier provided, claims will be denied. This requirement includes Medicare crossover claims.

Claims billed for a blood glucose monitor or diabetic test strip not listed in Table 1 require the addition of modifier U1, along with the NDC and appropriate procedure code. Claims billed for an NDC not on the PDSL will be denied. Medicare crossover claims require the appropriate modifier, and non-Medicare third-party liability (TPL) claims for nonpreferred blood glucose monitors or diabetic test strips require the U1 modifier.

Claims billed for an NDC included on the PDSL do not require the addition of modifier U1. If modifier U1 is included with a **preferred** blood glucose monitor or diabetic test strip NDC, the claim will be denied.

The modifiers NU (indicating a new product) and RR (indicating a rental product) are not used for E0607, E0607 U1, A4253, or A4253 U1 for supplies that are on the PDSL.

Claims for blood glucose monitors and diabetic test strips are priced according to the Fee Schedule, accessible from the [IHCP Fee Schedules](https://www.in.gov/medicaid/providers) page at [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers).

Continuous Glucose Monitors

Continuous glucose monitors are Food and Drug Administration (FDA)-approved devices used to record ongoing glucose levels in interstitial fluid. Continuous glucose monitoring provides information about glucose fluctuations that might not otherwise be obtained with traditional testing methods and alerts the user of impending dangerously low blood sugar. The purpose of continuous glucose monitoring is to provide additional information to the provider and the member in order to aid improved glycemic control and prevent dangerously low blood sugars.

Continuous glucose monitors are reimbursable for all ages by the IHCP for both short-term and long-term use when considered medically necessary. HCPCS codes A9277 and A9278 for long-term continuous glucose monitoring require MSRP documentation (or a cost invoice, if no MSRP is available for the item) be submitted with the claim.

Indications – General

Prior authorization based on the following criteria must be obtained for use of continuous glucose monitors for long-term or short-term monitoring:

- The member must have one of the following conditions:
 - Type 1 diabetes
 - Type 2 insulin-dependent diabetes
 - Pregnant with either type 1, type 2, or gestational diabetes
- The member must have shown compliance in his or her own care
- The member must meet at least one of the following:
 - The member must not have achieved the American Diabetes Association (ADA) recommended target hemoglobin A1C despite consistent self-blood glucose monitoring
 - The member has evidence of insulin-induced hypoglycemia occurring multiple times per week
- The member must show continued suboptimal diabetes control while utilizing multiple daily injections of insulin or an insulin pump to manage glucose levels
- The device used must be approved by the FDA for use in the age range appropriate for the member

The monitoring must be performed for a minimum of 24 hours. If the service is performed less than 24 hours, the service is not considered medically necessary.

Short-Term Continuous Glucose Monitoring – Up to 72 Hours

IHCP reimbursement is available for a continuous glucose monitor for up to 72 hours (three days) as an evaluation tool for providers to treat members who have not obtained acceptable glycemic control.

The CGM is deemed medically necessary when all the following criteria are met:

- The member is compliant with his or her own care and had been instructed by a health care professional regarding diabetic management.
- The member meets one of the following conditions:
 - Has type 1 diabetes
 - Has type 2 insulin-dependent diabetes
 - Is a pregnant woman with either type 1, type 2, or gestational diabetes

- The member has suboptimal glycemic control despite compliance with multiple daily injections of insulin (minimum of three injections per day) and documented frequency of standard self-monitoring of blood glucose (minimum of four times per day):
 - Hemoglobin A1C is >7.0% (ADA recommended goal)
 - Evidence of insulin-induced hypoglycemia (<50 mg/dL) occurring multiple times per week
 - Episodes of diabetic ketoacidosis or hypoglycemia resulting in loss of consciousness, seizure, or need for emergency health services

The 72-hour continuous glucose monitoring device should be used on appropriate periodic basis (as determined by medical necessity) in order to direct changes in diabetic management.

Long-Term Continuous Glucose Monitoring

IHCP reimbursement is available for long term continuous glucose monitoring when considered medically necessary and all the following criteria have been met:

- The member is compliant
- The member meets one of the following conditions:
 - Has Type 1 diabetes
 - Has Type II insulin dependent diabetes
 - Is a pregnant woman with either type 1, type 2, or gestational diabetes
- The member has one of the following:
 - Suboptimal glycemic control despite compliance with multiple daily injections of insulin (minimum of three injections per day) and documented frequency of standard self-monitoring of blood glucose (minimum of four times per day)
 - Evidence of insulin-induced hypoglycemia (<50 mg/dL) occurring multiple times per week
 - History of hypoglycemic unawareness resulting in loss of consciousness, seizure, or need for emergency health services
 - An insulin pump used for maintenance of blood sugar control.

Eyeglasses and Lenses

See the [Vision Services](#) module for information on eyeglasses and lenses.

Food Supplements, Nutritional Supplements, and Infant Formulas

Per 405 IAC 5-24-9, the IHCP provides coverage for food supplements, nutritional supplements, and infant formulas when no other means of nutrition is feasible or reasonable. Coverage is not available in cases of routine or ordinary nutritional needs. Coverage is also not available in cases in which the item is to be used for other than nutritional purposes.

In a long-term care (LTC) facility, costs for these products, when used either for nutritional supplementation or as the sole source of nutrition for the resident, are included in the facility's established per diem rate. When these products are furnished to an LTC facility resident, they are not separately reimbursable by the IHCP and should not be billed separately to the IHCP by either the LTC facility or another provider furnishing the products. The exception is hyperalimentation and total parenteral nutritional (TPN) products, which may be separately billed to the IHCP for residents of LTC facilities.

Prior authorization is required for all food supplements, infant formulas, and nutritional supplements, with the exception of hyperalimentation and TPN products.

The PA determination is made on a case-by-case basis, taking into consideration the feasibility or reasonableness of other means of nutrition, as documented by the requesting practitioner. Authorization is not granted when convenience of the member or the member's caretaker is the primary reason for the request for the service.

Infant Formula

Providers must coordinate with the appropriate entity when seeking approval for Medicaid coverage of infant formula. If the eligible member is assigned to FFS Medicaid on the date of service, Cooperative Managed Care Services (CMCS) is responsible for processing the required PA. Information about obtaining PA through CMCS can be found in the [Prior Authorization](#) module or on the [Prior Authorization](#) page at in.gov/medicaid/providers.

For members enrolled in HIP, Hoosier Care Connect, or Hoosier Healthwise managed care programs on the date of service, the member's MCE is responsible for approving Medicaid coverage of the infant formula. Each MCE has developed its own policy and procedure for how medical necessity for infant formula must be documented and approval obtained. See the [IHCP Quick Reference Guide](#) at in.gov/medicaid/providers for contact information.

While the member is awaiting authorization, the Women, Infants and Children (WIC) program will provide a supplemental amount of exempt infant formula or medical food. Pursuant to *Code of Federal Regulations 7 CFR 246.10(d)(1)(iii)* and *246.10(d)(1)(iv)*, to receive this WIC benefit, members must obtain documentation of a qualifying condition from a healthcare professional licensed to write medical prescriptions. Members should be referred to WIC only as a secondary provider. Medicaid becomes the primary provider after approval as a covered benefit is granted.

Enteral Nutrition

The IHCP requires PA for enteral nutrition. Each PA request for enteral nutrition items must include a completed *Certification of Medical Necessity: Parenteral and Enteral Nutrition* (available on the [Forms](#) page at in.gov/medicaid/providers). Someone other than the ordering physician is allowed to complete the certification of medical necessity (CMN); however, the ordering physician must review the information for the accuracy, sign, and date the CMN to indicate agreement.

After the initial PA of enteral nutrition items, the IHCP requires subsequent PA after 3, 9, and 18 months of therapy to document the member's continued need for therapy. After 2 years, the IHCP determines the need for further PA on a case-by-case basis. If the member does not medically require enteral nutrition services for 2 consecutive months, the IHCP requires a new PA, and the required extension schedule starts again.

For the initial PA or extensions of initial PA, providers must include additional documentation to support medical necessity of the following orders:

- The need for special nutrients
- The need for total caloric intake less than 20 cal/kg/day or greater than 35 cal/kg/day
- The need for a pump (see the [Parenteral and Enteral Nutrition Pumps for Home Infusion](#) section)

Food Thickener

The IHCP covers food thickener, when ordered by a physician, based on medical necessity, and subject to prior authorization. According to the *Health Insurance Portability and Accountability Act (HIPAA)*, only drugs and biologics may be reported on the pharmacy claim with an NDC. Nutritional supplements are not considered drugs or biologics and, therefore, should not be billed on a pharmacy claim. Bill nutritional supplements using the appropriate HCPCS procedure code on the professional claim (*CMS-1500* claim form or electronic equivalent).

Gloves

The IHCP provides coverage for sterile and nonsterile gloves for use in the home by the member, family, or other nonpaid caregiver. All gloves must be ordered in writing by a physician. Sterile gloves must be used only when medical conditions necessitate them.

Documentation of medical need is required for all gloves, nonsterile and sterile. The supplier must maintain a signed physician's order in the patient record, with a start and stop date, frequency of treatment, and type of treatment that makes the gloves medically necessary. Documentation must indicate the reason the physician ordered the gloves as part of the plan of care. Physicians must renew their orders at least every 12 months to ensure ongoing need for gloves. The order should reflect any changes in the plan of care in the home treatment setting. Providers must maintain records of quantities supplied. If these supplies are delivered or mailed, a record showing proof of delivery must be maintained.

The IHCP does not provide reimbursement for sterile or nonsterile gloves in the following situations:

- Gloves used in the home by a paid caregiver are noncovered.
- Gloves that are not used for a medically necessary treatment are noncovered.
- For end-stage renal disease (ESRD) and dialysis services, payment for gloves is included in the composite reimbursement rate and should not be billed separately.
- For members who reside in an LTC facility, gloves are included in the per diem reimbursement rate; therefore, gloves are not separately billable by the nursing facility or another provider.

Nonsterile Gloves

Nonsterile gloves are reimbursed only when used by the patient, family, or other nonpaid caregiver. Providers cannot bill the IHCP for any amount that exceeds their usual and customary charge to the general public. Providers should use partial units to bill nonsterile gloves individually in the units field of the professional claim. The partial unit is billed by entering the appropriate decimal indicator for the number of gloves used. For example, two gloves are billed as 0.02; 40 gloves are billed as 0.40.

One unit of A4927 equals 100 nonsterile gloves. Per IHCP guidelines, code A4927 is limited to five units (500 gloves) per month.

Examples of a medical need for a nonsterile glove include, but are not limited to, the following uses:

- A bowel program requiring manual evacuation
- An ostomy care program
- A wound care program
- Exposure to blood and body fluids

Sterile Gloves

Sterile gloves are reimbursable, when medically necessary, using procedure code A4930 – *Gloves, sterile, per pair*.

Medical necessity for sterile gloves includes, but is not limited to, the following:

- Tracheostomy changes
- Wound care for specified populations, such as those who are immunosuppressed or burn victims

Sterile gloves are not separately reimbursed when they are included in sterile procedure kits, such as catheter insertion kits and suture removal kits.

Hearing Aids

See the [Hearing Services](#) module for information about hearing aids.

High-Frequency Chest Oscillation Systems

A high-frequency chest wall oscillation system is a mechanical device that uses a vest and a generator to assist in loosening bronchial secretions and clearing the airway.

Prior authorization is required for all high-frequency chest wall oscillation systems. For IHCP approval and coverage, the following criteria must be met:

- A physician order
- The physician's determination that the member requires airway clearance therapy at least once a day
- A pulmonary function study, done within 90 days of the date of the request, that demonstrates:
 - A Forced expiratory volume (FEV1) 80% of predicted
 - A forced vital capacity (FVC) 50% of predicted
 - A 25% decrease on small airway score (forced expiratory flow [FEF] 25–75) over 1 year
- Documentation supporting that chest physiotherapy or flutter devices used twice a day have been ineffective in managing bronchial secretions
- Documentation supporting that family members and caregivers have been unable to provide effective chest therapy, or that the member is living independently or is away at school
- Risk of continued hospitalization for the member
- The member does not have a cardiac condition

The IHCP requires a 3-month rental of a high-frequency chest wall oscillation system before purchase of the equipment is covered or reimbursable. At the end of 3 months, documentation that the system has been used on a regular basis is required. Medical records must indicate the patient's compliance and tolerance before the IHCP will approve the purchase.

The 3-month rental requirement pertains only to the generator system. Reimbursement for the replacement vest and hose are purchase only.

Hospital and Specialty Beds

The IHCP provides coverage for hospital and specialty beds when they are medically necessary in a noninstitutional setting, when there is a written physician's order, and when prior authorization has been received for the bed.

The IHCP designates hospital and specialty beds according to the following definitions:

- Hospital Beds
 - A *fixed-height hospital bed* is one with manual adjustment elevation for head and leg.
 - A *variable-height hospital bed* is one with manual adjustment elevation for the head, height, and legs.
 - A *semi-electric hospital bed* is one with manual adjustment elevation for height and with electric elevation adjustments for the leg and head.
 - A *total-electric hospital bed* is one with electric elevation adjustments for height, head, and leg.

- Specialty Beds
 - An *enclosed bed* is one that is a single piece of equipment (for example, a bed and mesh canopy, or a bed with padded walls and a mattress especially designed for patients with traumatic brain injury [TBI]).
 - A *pediatric hospital bed* has higher side rails that are close together to prevent injury from falling through the rails. Pediatric hospital beds usually also have a protective covering over the rails.

Prior authorization is required for all types of hospital beds and specialty beds. The following items are required with the PA request for all hospital and specialty beds:

- A written physician's order
- A completed *Medical Clearance Form for Hospital and Specialty Beds* (available on the [Forms](#) page at in.gov/medicaid/providers) signed by a physician
- Documentation of medical necessity in a noninstitutional setting
- Appropriate diagnosis demonstrating medical necessity for a bed

For requirements specific to each type of bed, see the following subsections.

Hospital Beds

A hospital bed is considered medically necessary if **one or more** of the following conditions are met:

- A physician ordered positioning of the body in ways not feasible with an ordinary bed, and the order is due to a medical condition that is expected to last at least 1 month; elevation of the head and upper body needs to be greater than 30°.
- A physician ordered positioning of the body to alleviate pain in ways that are not possible in an ordinary bed.
- A physician ordered positioning of the body in a way that requires head elevation greater than 30 degrees most of the time.
 - The need for head elevation must be related to a medical condition, such as congestive heart failure, chronic pulmonary disease, or problems with aspiration.
 - Pillows or wedges must have been tried and failed.
- A physician ordered traction that requires traction equipment that can be attached only to a hospital bed.

A variable-height hospital bed is covered if, in addition to meeting one or more of the preceding criteria for a hospital bed, the physician orders a bed height different from a fixed-height hospital bed to accommodate transfers to a chair, wheelchair, or standing position.

A semi-electric hospital bed is covered if, in addition to meeting one or more of the above criteria for a hospital bed, the physician orders frequent changes in body positioning or the patient has an immediate need for a change in body position.

Enclosed or Cubicle Bed

An enclosed bed or cubicle bed is considered medically necessary when **all** the following criteria are met:

- An appropriate diagnosis that could include but is not limited to the following:
 - Severe intellectual disabilities
 - Profound intellectual disabilities
 - Leukodystrophy
 - Picks disease

- Obstructive hydrocephalus
- Infantile cerebral palsy
- Generalized convulsive epilepsy
- Grand mal status epileptic
- Anoxic brain damage
- Convulsions
- Intracranial injury of other and unspecified nature
- Documentation of medical necessity, including at least one of the following:
 - Daily seizure activity
 - Uncontrolled perpetual movement related to diagnosis
 - Self-injurious behavior, such as uncontrolled head banging
- Documentation of safety factors tried and failed, including but not limited to the following:
 - Chest restraints
 - Side rails
 - A mattress on the floor
 - Protective helmet
- Supporting documentation including secondary diagnoses and pertinent history, such as:
 - History of injuries or falls
 - High risk for fractures due to osteoporosis
 - At risk for hemorrhage due to thrombocytopenia
 - Frequent upper-respiratory infections or other complications related to aspiration
 - Respiratory complications related to positioning, requiring elevation of the head and upper body greater than 30 degrees
 - Requires frequent positional changes
- A signed physician's order for enclosed bed or cubicle bed
- Verification that the primary caregiver is willing and able to clean and maintain the mesh canopy per the manufacturer recommendations. IHCP will not pay for laundering of the mesh canopy.

Pediatric Hospital Bed

Pediatric hospital beds are considered medically necessary when **all** the following criteria are met:

- A medically necessary diagnosis, which could include but is not limited to the following:
 - Tracheostomy
 - Gastrostomy
 - Heart failure
 - Pleural effusion, except tuberculous
 - Acute respiratory failure
 - Pulmonary insufficiency
 - Diseases of the lung
 - Diseases of trachea and bronchus
 - Respiratory distress syndrome in newborn
 - Other respiratory problems after birth
 - Other symptoms involving respiratory system and chest
- A physician's order for a multi-positional bed due to of the need for frequent position changes

- Elevation of upper body and head greater than 30 degrees
- Written documentation of why a standard crib is not appropriate and what alternative methods have been tried and failed
- Documentation of at least **one** of the following:
 - A risk for aspiration pneumonitis or gastric reflux related to disease
 - A history of aspiration pneumonitis

Incontinence, Ostomy, and Urological Supplies

The IHCP covers incontinence supplies for members 3 years old or older, based on medical necessity. The following restrictions apply for FFS billing:

- A member may receive a maximum of \$162.50 per month for all incontinence supplies.
- A member may receive a maximum of \$1,950 per calendar year for all incontinence supplies.

Providers may supply such items to an IHCP member only in 30-day increments. Although a physician may write an order for a longer period of time, providers must provide each member with only a 30-day supply at a time.

Documentation Requirements

The IHCP requires documentation of medical necessity for all incontinence supplies. The physician should maintain documentation of the medical necessity for the supplies in the patient's record. The clinical documentation must include a diagnosis of incontinence. The incontinence diagnosis must also be documented on the professional claim (*CMS-1500* claim form or electronic equivalent), with information about the specific quantity and description of the supplies provided.

Incontinence supplies must be ordered in writing by a physician. The written order should include, at a minimum, the following information, when applicable:

- Patient's name
- Date ordered
- Physician's signature
- Area of body for use (for items that may be appropriate for multiple sites)
- Detailed list of supplies ordered (including type and size of the product)
- Quantity intended for use
- Frequency of use (for example, change dressing three times per day)
- Anticipated duration of need (including start and stop dates)

The supplier must maintain the signed physician's order in the IHCP member's record for audit purposes.

The physician's order must be renewed annually, at minimum. For example, an order written on February 15, 2018, is effective for a maximum of 12 months, through February 14, 2019. The supplier must obtain a new order to cover dates of service starting February 15, 2019. The supplier must have a current order to initiate or continue the provision of supplies to an IHCP member.

In addition to the signed physician's order, the supplier must maintain documentation in the member's medical record of proof of delivery. Documentation must include the following:

- Date of delivery
- Address of delivery
- Signature of the IHCP member, caregiver, or family member who received the supplies
- Specific quantity and description (such as brand, type, size, and so forth) of the supplies provided

Nursing Assessment Requirements

Members are required to participate in a nursing assessment to determine the appropriate products, brands, and quantities of incontinence, ostomy, or urological products needed. All nursing assessments must be performed by a licensed nurse who is employed by the supplying provider.

Contracted Vendor Requirements

FFS members, including those in the Traditional Medicaid program, are required to obtain incontinence, ostomy, and urological supplies – including but not limited to diapers, underpads, ostomy bags, and gloves – through mail order from one of the following IHCP-contracted providers:

- **Binson's Home Health Care Centers**
binsons.com
Telephone: 1-888-217-9610
- **J&B Medical Supply Company**
jandbmedical.com
Telephone: 1-866-674-5850

Noncontracted vendors and other caregivers should encourage members who require incontinence, ostomy, and urological supplies to contact one of the two contracted vendors to obtain supplies. FFS claims for these supplies from noncontracted vendors will be systematically denied, except in the following situations:

- Members enrolled in the 590 Program, First Steps, Medical Review Team (MRT), Preadmission Screening and Resident Review (PASRR), LTC, or a managed care program are excluded from this policy requirement.
- IHCP members with Medicare or other third-party insurance must follow the guidelines of their primary insurance plan to receive reimbursement for incontinence, ostomy, and urological supplies. Crossover claims and claims with a third-party payment amount indicated for these supplies are not affected by the IHCP-contracted-vendor or 30-day-supply requirements, as long as Medicare or the primary carrier provided coverage for the product and coverage was in effect on the date of service.

Before supplying these products to FFS IHCP members, providers must verify the member's Medicare or primary carrier eligibility and product coverage for the date of service. If coverage under Medicare or the primary carrier does not apply to the date or type of service, the claims will be subject to IHCP policy requiring these supplies to be provided by one of the two contracted vendors. If Medicare or the primary carrier does not cover this type of service, the claim is processed following Medicaid rules, as though Medicaid is primary. In this case, claims from a noncontracted vendor are denied.

Some products that *may* be used for incontinence, ostomy, or urological conditions – such as adhesive and adhesive remover, lubricant, gloves, and skin barriers – also have other, *unrelated* uses. When these supplies are used for purposes unrelated to incontinence, ostomy, or urological conditions, they are not affected by the IHCP-contracted vendor requirement, and may be obtained from any appropriate IHCP-enrolled provider (including but not limited to the contracted vendors).

For a list of procedure codes for incontinence, ostomy, and urological supplies that must be purchased from a contracted vendor for FFS coverage, see the *Incontinence, Ostomy, and Urological Supplies Available Only through Contracted Vendors for Fee-for-Service Members* table in *Durable and Home Medical Equipment and Supplies Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

Prior Authorization for High-End Incontinence Products

PA is not required for the reimbursement of incontinence supplies unless they are supplied by an out-of-state provider or the member is using high-end incontinence products.

Prior authorization for high-end incontinence products will be granted based on medical necessity. At minimum, the following information must be submitted to determine medical necessity:

- Documentation from the member that he or she has sampled all applicable products from the two vendors and indicating why the products sampled were not appropriate (for example, leakage, skin breakdown, and so on).
- Documentation supporting medical necessity for the high-end ostomy supplies. The documentation must include one or more of the following:
 - Recurrent infections or skin breakdown
 - Issues the member is having with the current product (allergic reaction, redness, irritation, and so on)
 - Enzymes dissolving the adhesive or causing skin breakdown
- Documentation of the actual quantity needed per month for the member and factors that affect the frequency of the change

HCPSC procedure codes for high-end incontinence products are indicated by an asterisk on the *Incontinence, Ostomy, and Urological Supplies Available Only through Contracted Vendors for Fee-for-Service Members* table in *Durable and Home Medical Equipment and Supplies Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers. Claims for these procedure codes must include the U9 modifier to process correctly.

Incontinence Supplies for Group Homes, ICF/IIDs, and Long-Term Care Facility Residents

The IHCP reimburses incontinence supplies for members residing in group homes, ICFs/IID, and LTC facilities through the *per diem* rate for the facility, and the facility or any other provider cannot bill separately for these supplies.

Negative Pressure Wound Therapy

The IHCP provides coverage for negative pressure wound therapy (NPWT) in a home-care setting or an LTC facility setting, with prior authorization, based on the following criteria:

- The member must have a physician's order.
- The NPWT must be reasonable and medically necessary.
- The member must have one of the following conditions:
 - Stage III or IV pressure ulcer
 - Neuropathic ulcer
 - Venous or arterial insufficiency ulcer
 - Chronic (being present for at least 30 days) ulcer of mixed etiology
 - Traumatic or surgically created wound
- A complete wound-therapy program, described in the following sections, depending on the type of wound, must have been tried and failed before applying the NPWT.

Wound-Therapy Program Requirements

For all ulcers or wounds, **all** the following minimum general measures of a wound-therapy program must be addressed, applied, or considered and ruled out before applying the NPWT:

- Documentation in a patient's medical record of evaluation, care, and wound measurements by a licensed medical professional
- Application of dressings to maintain a moist wound environment
- Debridement of necrotic tissue and treatment of active infection, if present
- Evaluation of and provision for adequate nutritional status
- Ensure adequate wound perfusion

Stage III or IV Pressure Ulcers

In addition to the minimum general measures, stage III or IV pressure ulcers must also be evaluated for all of the following components:

- The patient has been appropriately turned and positioned, and has a current turning and positioning plan in place.
- If the wound is on the trunk or the pelvis, the patient has used a group 2 or group 3 support surface.
- The patient's moisture and incontinence has been appropriately managed.

Neuropathic Ulcers

In addition to the minimum general measures, neuropathic ulcers must also be evaluated for all of the following components:

- The patient has been on a comprehensive diabetic or other applicable disease management program.
- Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.

Venous Stasis Ulcers

In addition to the minimum general measures, venous stasis ulcers must also be evaluated for all the following components:

- Compression bandages or garments have been consistently applied.
- Leg elevation and ambulation have been encouraged.

Prior Authorization for NPWT

Prior authorization is required for reimbursement of NPWT. The PA request must include a completed *Medical Clearance Form for Negative Pressure Wound Therapy* (available on the [Forms](#) page at in.gov/medicaid/providers), signed by the physician.

The NPWT is authorized for only 4 weeks at a time. To obtain PA for continued service after the initial PA of NPWT, documentation of the following must be included with the request:

- Indication that a licensed medical professional has directly performed or supervised the performance of the dressing changes
- A statement from the treating physician describing the initial condition of the wound, including measurements, efforts taken to address wound care, and the changes in the wound therapy being applied to affect wound healing

- Progress and changes in the ulcer (If there is no progress in 1 month, or from month to month, the approval for the NPWT will be discontinued.)
- A completed NPWT medical clearance form, signed and dated by the ordering physician

Each new physician's order for continued use of NPWT requires a new PA period. If a PA is modified and authorized for less time than the physician's order had requested initially, a new PA form and updated physician's orders must be obtained before the current authorization expires.

Authorization for coverage beyond 4 months in a home-care setting will be given individual consideration, based on additional documentation that sets out the reason for continuing use of NPWT.

Supplies

Supplies for the NPWT must also be prior authorized. Each dressing set equals one unit.

No more than 15 units for dressing sets, any size, will be authorized per wound, per month. No more than 10 canisters, any size, per wound, per month, will be authorized unless documentation is submitted with the request to identify proof of an increased amount of supplies.

Orthopedic or Therapeutic Footwear

See the [Podiatry Services](#) module for information about reimbursement for orthopedic footwear, orthopedic shoe additions, and corrective features built into shoes, such as heels, lifts, wedges, arch supports, and inserts.

Osteogenic Bone Growth Stimulators

The IHCP provides reimbursement for osteogenic bone-growth stimulators when the service is considered medically necessary and provided in compliance with all IHCP guidelines. Prior authorization is required for osteogenic bone-growth stimulators.

Indications

For authorization of an osteogenic bone-growth stimulator, the diagnosis of a nonunion fracture must meet the following criteria:

- Serial radiographs must have confirmed that the healing of the fracture has ceased for 3 or more months prior to starting treatment with an osteogenic stimulator.
- Serial radiographs must include a minimum of two sets of radiographs, each including multiple views of the fracture site, separated by a minimum of 90 days.

In addition, the member must meet medical criteria specific to the type of device being requested:

- **Noninvasive electrical stimulators** are covered only for the following indications:
 - Nonunion of long bone fractures
 - Congenital pseudoarthrosis
 - As an adjunct to spinal fusion surgery for patients at high risk of pseudoarthrosis due to previously failed spinal fusion at the same site, or for those undergoing multiple-level fusions(fusions involving three or more vertebrae, such as L3–L5 or L4–S1)
- **Noninvasive ultrasonic stimulators** are covered for the following indication:
 - Nonunion of a fracture documented by a minimum of two sets of radiographs obtained prior to starting treatment with the ultrasonic stimulator; radiographs must be separated by a minimum of 90 days, and each must include multiple views of the fracture site. Written interpretation by a physician must state that there has been no clinically significant evidence of the fracture healing between the two sets of radiographs.

Note: The ultrasonic osteogenic stimulator may not be used concurrently with other noninvasive osteogenic devices.

- **Implantable stimulators** – See the [Surgical Services](#) module for coverage requirements.

Contraindications

The IHCP excludes nonunions of the skull and vertebrae, and those that are tumor-related, from coverage.

The IHCP does not cover treatment for fresh fractures or nonunion associated with osteomyelitis.

Oximetry

Oximetry for oxygen saturation is performed with an oximeter device that can be appropriately billed with HCPCS code E0445 – *Oximeter device for measuring blood oxygen levels noninvasively*.

The device is available for rental using the RR modifier or purchase using the NU modifier. Rental of noninvasive pulse oximeters includes all cords, batteries, alarms, sensors, probes, printers, and all supplies.

Oximetry determination should be billed using the appropriate CPT code. IHCP reimbursement for noninvasive pulse oximetry determination is available using the following CPT codes:

- 94760 – *Non-invasive ear or pulse oximetry for oxygen saturation; single determination*
- 94761 – *Non-invasive ear or pulse oximetry for oxygen saturation; multiple determinations*
- 94762 – *Non-invasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring*

Reimbursement of codes 94760, 94761, and 94762 includes the physician interpretation of the oximetry results and any related equipment. Noninvasive pulse oximetry is not separately reimbursable during a pneumogram.

For CPT code 94762, one unit of service equals 1 day. Use this code for billing oximetry service on a daily basis, up to and including a maximum of eight units of service per month. If a member requires more than eight units per month, the device can be rented and billed using E0445 RR, instead of CPT code 94762. Purchase of an oximetry system, E0445 NU, is appropriate for an expected long-term need where the cost to purchase the system is less than the expected monthly rental charges.

PA is not required for noninvasive pulse oximetry or the oximeter device.

Oxygen and Home Oxygen Equipment

The IHCP reimburses liquid and gaseous oxygen systems as rental items only. The oxygen system does not fall under capped rental guidelines. Prior authorization based on medical necessity is required.

Oxygen and oxygen equipment reimbursement includes the system for furnishing oxygen, the vessels that store the oxygen, the tubing and administration sets that allow the safe delivery of the oxygen, and the oxygen contents:

- The IHCP includes oxygen contents in the rental allowance. Oxygen contents are separately reimbursable only when a third-party has purchased an oxygen system, or the IHCP or third party has rented or purchased a portable oxygen system.
- The IHCP also includes accessories (including but not limited to cannulas, masks, and tubing) in the allowance for rented systems. The IHCP separately reimburses for these items only when they are used with a **purchased** oxygen system.

- Spare tanks of oxygen and emergency oxygen inhalators are denied as medically unnecessary, because they are considered precautionary and not therapeutic in nature.

For all oxygen codes, one unit equals 1 month. Providers must indicate 1 month of service on the professional claim by entering a **1** in the units field for the service billed.

Long-Term Care Facility Considerations

The facility, pharmacy, or other provider cannot bill the IHCP for oxygen, oxygen equipment, or supplies for oxygen delivery for the usual care and treatment of members in LTC facilities. The IHCP includes reimbursement for these items in the facility *per diem* rate. If a member in an LTC facility requires nonstandard equipment, these items may be eligible for separate reimbursement. The IHCP requires PA for nonstandard equipment and associated repair costs. Facilities cannot require members to purchase or rent such equipment with the member's personal funds.

PA is required for oxygen concentrators, except when used for LTC facility residents certified by a physician as needing oxygen therapy.

Prior Authorization Requirements

For members receiving oxygen services in a home setting, the IHCP requires PA for all oxygen and associated equipment and supplies, including concentrators and portable liquid oxygen equipment.

The ordering physician must complete, sign, and date the *Certification of Medical Necessity: Oxygen (CMS-484)* form (available on the [Forms](#) page at in.gov/medicaid/providers) and submit it with the PA request. The *CMS-484* is the same form currently accepted by Medicare. Providers must keep the *CMS-484* on file. Providers should use this form for initial PA, subsequent PA extensions, and changes in the prescriptions. The IHCP does not require a separate order, because the order information is incorporated in the certification of need.

The IHCP requires PA renewals at least annually. Providers should submit a new PA and *CMS-484* whenever there is a change in the oxygen prescription, such as an increase or decrease in oxygen flow rate or different equipment ordered, or if there is a change in the attending physician. In addition, the IHCP may require subsequent extensions in individual cases. For more information on obtaining PA, see the [Prior Authorization](#) module.

Authorization of home oxygen therapy is based on the medical criteria indicated in the following section.

Indications

The IHCP covers home oxygen therapy only for patients with significant hypoxemia in the chronic stable state, provided the following are met:

- The attending physician has determined that the patient has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen.
- The patient's blood gas levels indicate the need for oxygen therapy.
- The physician has tried or considered alternative treatment measures and has deemed them clinically ineffective.
- The patient meets the criteria in one of the category groups as presented in the following sections.

Group I Criteria

- The patient demonstrates an arterial PO₂ at or below 55 mm Hg or an arterial oxygen saturation at or below 88%, taken at rest.
- The IHCP provides coverage **only for nocturnal use** of oxygen in the following cases:
 - The patient demonstrates an arterial PO₂ at or below 55 mm Hg or an arterial oxygen saturation at or below 88% during sleep, and the patient demonstrates an arterial PO₂ (oxygen partial pressure) at or above 56 mm Hg or an arterial oxygen saturation at or above 89% while awake.
 - The patient demonstrates a greater than normal fall in oxygen level during sleep, a decrease in arterial PO₂ more than 10 mm Hg, or a decrease in arterial oxygen saturation of more than 5%, associated with symptoms or signs reasonably attributable to hypoxemia, such as cor pulmonale, P pulmonale on EKG, documented pulmonary hypertension, or erythrocytosis.
- The IHCP provides coverage **only during exercise** if the patient demonstrates an arterial PO₂ at or below 55 mm Hg or an arterial oxygen saturation at or below 88% taken during exercise and an arterial PO₂ at or above 56 mm Hg or an arterial oxygen saturation at or above 89% taken during the day while at rest. In this case, the IHCP provides supplemental oxygen during exercise if it is documented that the use of oxygen improves the hypoxemia that was documented during exercise when the patient was breathing room air.

Group II Criteria

- The patient demonstrates an arterial PO₂ of 56 to 59 mm Hg or an arterial blood oxygen saturation of 89% **and** any of the following:
 - Dependent edema suggesting congestive heart failure
 - Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or P pulmonale on EKG, P wave greater than 3 mm in standard leads II, III, or AVF
 - Erythrocythemia with a hematocrit greater than 56%

Group III Criteria

- The IHCP requires additional documentation to substantiate use of oxygen when the patient demonstrates an arterial PO₂ level at or above 60 mm Hg or an arterial blood oxygen saturation at or above 90%. Providers should ensure that additional documentation appears on the PA form or an attached form, indicating the type, frequency, and severity of incidents or episodes.
- Episodes include, but are not limited to, the following:
 - Apnea conditions
 - Bronchopulmonary dysplasia
 - Cerebral palsy
 - Cyanotic congenital heart disease
 - Episodic attacks of acute and severe asthma
 - Intermittent cyanosis or dyspnea documented by clinical observation
 - Intermittent upper airway obstruction
 - Neuromuscular disorders extensive enough to affect pharyngeal and chest muscles, and that clinically interfere with normal breathing
 - Severe recurrent attacks of epilepsy
 - Significant intellectual disability with repetitive episodes of respiratory difficulties
 - Tracheal laryngeal malacia

The IHCP may give PA to patients who fall into Group III for 3, 6, or 12 months, depending on the medical necessity demonstrated in the documentation provided. If PA is not waived based on one of the preceding criteria, the IHCP determines whether to require retesting using arterial blood gas (ABG) or transcutaneous oximetry readings when and if authorization is granted. Providers must include such benefits, or the results of the latest ABG or oximetry readings, on the CMN form when submitted with the new PA request.

Note: The IHCP accepts transcutaneous oximetry in lieu of arterial or capillary blood gases for oxygen monitoring. A physician or provider other than a DME supplier, certified to conduct such tests, must conduct the measurement of these tests. The IHCP does not extend this prohibition to tests conducted by a hospital that may also be furnishing home oxygen therapy to the patient directly or through an associated organization.

Certification Requirements for Oxygen Therapy Following an Inpatient Stay

The following coverage and payment rules apply to oxygen therapy when supplied for members in the home setting following an inpatient stay.

The IHCP requires recertification 3 months after initial certification for inpatients in the following cases:

- For inpatient members whose arterial PO₂ was 56 mm Hg or greater or whose oxygen saturation was 89% or greater on the initial certification
- For inpatient members whose physician's initial estimate of length of need for oxygen was 1 to 3 months
- If the first situation applies, repeat testing must be performed between the 61st and the 90th days of home oxygen therapy

For members for whom the IHCP does not require recertification at 3 months, the IHCP requires recertification at 12 months after the initial certification.

The IHCP requires initial certification and 3-month recertification when the initial PO₂ is 56 mm Hg or greater or oxygen saturation is 89% or greater. Documentation must include the results of a recently performed ABG or oximetry test. The IHCP does not require retesting for recertification at 12 months, but providers must include on the form the results of the most recent ABG or oximetry test representing the patient's chronic stable state. The form must specify whether tests were performed while on room air or on oxygen, and specify the amount. The form must specify whether the patient was at rest, sleeping, or exercising when the test was performed.

Parenteral and Enteral Nutrition Pumps for Home Infusion

The IHCP covers parenteral and enteral nutrition (PEN) pumps for home infusion.

For information about enteral nutrition items, see the [Food Supplements, Nutritional Supplements, and Infant Formulas](#) section of this document.

Prior Authorization and Certification of Medical Necessity

Prior authorization is required for enteral nutrition. The IHCP does not require PA for the total parenteral nutrition or infusion pumps when used in conjunction with parenteral hyperalimentation, including central venous catheters.

The IHCP requires the *Certification of Medical Necessity: Parenteral and Enteral Nutrition* (available on the [Forms](#) page at in.gov/medicaid/providers) for all PEN pumps. The IHCP allows someone other than the ordering physician to complete the certification of medical necessity (CMN); however, the ordering physician must review for the accuracy of the information, sign, and date the CMN to indicate agreement. Providers must submit a copy of the CMN with the initial, and each subsequent, PA request for enteral and applicable parenteral nutrition items.

The IHCP requires subsequent PA after 3, 9, and 18 months of therapy to document the member's continued need for therapy. After 2 years, the IHCP determines the need for further PA on a case-by-case basis. If the member does not medically require enteral nutrition services for 2 consecutive months, the IHCP requires a new PA, and the required extension schedule starts again.

For the initial PA or extension of initial PA, providers must include additional documentation to support medical necessity of the following orders:

- The need for special nutrients
- The need for total caloric intake less than 20 cal/kg/day or greater than 35 cal/kg/day
- The need for a pump

Billing and Reimbursement

The following three provider types may bill for parenteral and enteral therapy provided in a member's home:

- DME and HME medical supply dealers
- Home health agencies
- Pharmacies

Providers must bill separately for the components for parenteral and enteral home infusion therapy:

- DME and HME providers bill all **supplies and formulas** used for parenteral and enteral home infusion on the professional claim (*CMS-1500* claim form or electronic equivalent) using the appropriate HCPCS codes.
- Home health agencies bill **services** provided by a registered nurse (RN), licensed practical nurse (LPN), or home health aide on the institutional claim (*UB-04* claim form or electronic equivalent) using the appropriate HCPCS codes for services provided.

Providers can bill parenteral and enteral services and therapies received by dual-eligible members (Medicare and Traditional Medicaid) to Medicare or Medicare Replacement Plans and the IHCP as crossovers. The provider must submit these services on the institutional claim (*UB-04* claim form or electronic equivalent).

See the Fee Schedules, accessible from the [IHCP Fee Schedules](#) page at in.gov/medicaid/providers for a comprehensive list of covered procedures.

Note: The IHCP does not routinely use HCPCS S codes when other national codes are available for the same services. The IHCP does not reimburse HCPCS S codes for home infusion therapy and enteral therapy. Providers must separately bill the appropriate national codes, using the proper billing format, to receive reimbursement for services described in HCPCS S codes for home therapy, including home infusion and enteral therapy.

PEN pumps are capped rental items. The IHCP makes no more than 15 monthly rental payments; at the end of the 15-month rental period, the pump becomes the property of the IHCP. If there is medical necessity for rental of the pump past the 15-month rental limit, the supplier is entitled to periodic servicing payments. See the [Capped Rental Items](#) section for more information.

For **enteral** pumps, the IHCP pays no more than one-half the rental payment every 6 months, beginning 6 months after the last rental payment. For **parenteral** pumps, the IHCP pays no more than one-half the rental payment every 3 months, beginning 3 months after the last rental payment. The supplier should keep written proof of servicing of enteral and parenteral pumps on file.

Servicing and Repairs

Necessary servicing of pumps may include repairs that require specialized testing equipment not available to the member or nursing home. The IHCP pays for only actual servicing. However, providers must obtain prior authorization for reimbursement for repair or servicing not covered by warranty. When requesting PA for repair services, providers must include an itemized list of materials and labor with the PA request. When submitting the claim for payment, providers must attach a materials-and-labor itemization plus a manufacturer's invoice to the claim. The IHCP reimburses the materials needed for repair at 20% above the manufacturer's cost to the provider.

Phototherapy (Bilirubin Light)

PA is not required for phototherapy. Use the following parameters for phototherapy billing:

- One unit of service equals 1 day.
- This service is limited to 15 units per lifetime of the member.
- Use procedure code E0202 RR (rental) when billing for phototherapy.

Pneumatic Artificial Voicing Systems

The IHCP reimburses for a pneumatic artificial voicing system (also known as an artificial larynx), subject to PA. The IHCP grants PA only when the provider sends the following:

- Documentation substantiating that the member demonstrates sufficient mental and physical ability to benefit from the use of the system
- Documentation substantiating that the member demonstrates sufficient articulation and language skills to benefit from the use of the system

When a provider supplies a pneumatic artificial voice system or an artificial larynx to a member on an inpatient basis, the attendant costs fall under the established *per diem* rate for the hospital or LTC facility. The provider should not bill separately for attendant costs.

Pneumograms

Providers should bill pneumograms using CPT code 94772 – *Circadian respiratory pattern recording (pediatric pneumogram), 12-24 hour continuous recording, infant*. CPT code 94772 includes technical and professional components of service. Providers should use modifier TC when billing only the technical component, or modifier 26 when billing only the professional component.

The IHCP does not require PA for pneumograms. The IHCP considers one pneumogram, with any number of channels, to be one unit. The IHCP does not separately reimburse for oximetry during a pneumogram because oximetry is included in the pneumogram reimbursement.

Prosthetic Devices

The IHCP reimburses for prosthetic devices under the following conditions:

- A physician, optometrist, or dentist must order all prosthetic devices in writing.
- When the basic prosthesis is approved, all customizing features are exempt from PA. The IHCP does not cover prosthetic devices dispensed for purely cosmetic reasons.

The IHCP allows separate reimbursement of specific prosthetic codes when rendered in the outpatient setting. See the [Orthotic and Prosthetic Codes in the Outpatient Setting](#) section of this document for details.

Respiratory Assist Devices – Continuous Positive Airway Pressure (CPAP) and Bi-Level Positive Airway Pressure (BiPAP)

The IHCP covers the following three types of respiratory assist devices (RADs) for eligible members who meet specific medical criteria:

- Continuous positive airway pressure (CPAP) devices
- Bi-level positive airway pressure (BiPAP) devices with a backup rate feature
- BiPAP devices without a backup rate feature

When the RAD (CPAP or BiPAP) is owned by the member, the IHCP reimburses RAD accessories according to specific limitations. Otherwise, the cost of the accessories is included in the rental reimbursement rate for the device.

For a list of procedure codes for RADs and RAD accessories, see *Durable and Home Medical Equipment and Supplies Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers. For information about humidifiers used with a RAD, see the [Humidifiers Used with a Positive Pressure Airway Device](#) subsection.

Continuous Positive Airway Pressure (CPAP)

The IHCP reimburses for CPAP systems for members who meet one or more of the following criteria:

- A diagnosis of OSA with an apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) equal to or greater than 15 events per hour documented in a recorded polysomnography
- A diagnosis of OSA with an AHI or RDI from 5–14 events per hour documented in a recorded polysomnography, with one or more of the following documented symptoms of:
 - Excessive daytime sleepiness
 - impaired cognition
 - Mood disorders
 - Insomnia or hypertension
 - Ischemic heart disease
 - History of stroke
- A diagnosis of moderate or severe OSA in a member for whom surgery is a likely alternative to CPAP

CPAP devices do not require prior authorization. However, copies of the member's sleep lab evaluation, including a polysomnography, must be retained in the physician's record.

Bi-Level Positive Airway Pressure (BiPAP)

The IHCP provides reimbursement for BiPAP with backup or BiPAP without backup, with prior authorization, for members that meet specified criteria:

- Coverage will be considered when the physician's documentation includes a statement that the member is experiencing symptoms of sleep-associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, or dyspnea.
- Medical necessity must be documented.

First 3 Months of Therapy

BiPAP devices are covered for the first 3 months of therapy for members with clinical disorders characterized in the following sections, when all listed criteria are met.

Note: For members under the age of 19, appropriate noninvasive testing (such as capillary blood gas and end tidal CO₂ tests) may be substituted in place of an arterial blood gas PaCO₂ test to meet medical criteria for all conditions. All other required criteria listed under each condition must be followed.

Restrictive Thoracic Disorders

A BiPAP device with or without backup (based on the judgment of the treating physician) may be covered for the first 3 months of therapy for members with restrictive thoracic disorders if all the following criteria are met:

- One of the following conditions is documented in the member's medical record:
 - A progressive neuromuscular disease (for example, amyotrophic lateral sclerosis)
 - A severe thoracic-cage abnormality (for example, post-thoracoplasty for tuberculosis)
- One of the following measurements has been demonstrated for the member:
 - An arterial blood gas PaCO₂, done while the member is awake and breathing the member's usual fraction of inspired oxygen (FiO₂), is greater than or equal to 45 mm Hg.
 - Sleep oximetry, done while breathing the member's usual FiO₂, demonstrates oxygen saturation of less than or equal to 88% for at least 5 continuous minutes.
 - For members with a progressive neuromuscular disease only – Maximal inspiratory pressure is less than 60 cm H₂O, or forced vital capacity is less than 50% predicted.
- Chronic pulmonary disease does not contribute significantly to the member's pulmonary limitation.

Severe Chronic Obstructive Pulmonary Disease

A BiPAP device **without backup** may be covered for the first 3 months of therapy for members with chronic obstructive pulmonary disease (COPD) if all the following criteria are met:

- An arterial blood gas PaCO₂, done while the member is awake and breathing the member's usual FiO₂, is greater than or equal to 52 mm Hg
- Sleep oximetry, done while the member is breathing oxygen at 2 liters per minute (LPM) or the member's usual FiO₂ (whichever is higher), demonstrates oxygen saturation less than or equal to 88% for at least 5 continuous minutes
- Prior to initiating therapy, OSA and treatment with CPAP have been considered and ruled out.

A BiPAP device **with backup** will usually *not* be covered for a member with COPD during the first 2 months, because therapy with a BiPAP device without backup – with properly adjusted settings and the member’s accommodation to its use – usually results in sufficient improvement without the need of a backup rate. After the first 2 months of therapy, a BiPAP device with backup may be covered for members with COPD if all the following criteria are met:

- Arterial blood gas PaCO₂ – repeated no sooner than 61 days after initiation of compliant use of a BiPAP device without backup and done while the member is awake and breathing the member’s usual FiO₂ – remains greater than or equal to 52 mm Hg.
- Sleep oximetry – repeated no sooner than 61 days after initiation of compliant use of a BiPAP device without backup and while the member is breathing oxygen at 2 LPM or the member’s usual FiO₂ (whichever is higher) using the BiPAP device without backup – demonstrates oxygen saturation less than or equal to 88% for at least 5 continuous minutes.
- A signed and dated statement from the treating physician is completed no sooner than 61 days after the initiation of the BiPAP device without backup, declaring that the member has been compliantly using the BiPAP device without backup an average of 4 hours per 24-hour period, but that the member is not benefiting from its use. The statement should also say that the physician believes that the member meets the listed criteria for a BiPAP device with backup.

Obstructive Sleep Apnea

A BiPAP device **without backup** may be covered for the first 3 months of therapy for members with obstructive sleep apnea (OSA) if both the following criteria are met:

- A complete facility-based, attended polysomnogram has established the diagnosis of OSA.
- A single-level device (CPAP) has been tried and proven medically ineffective.

A BiPAP device **with backup** is not medically necessary if the primary diagnosis is OSA.

Central Sleep Apnea

A BiPAP device with or without backup (based on the judgment of the treating physician) may be covered for the first 3 months of therapy for members with central sleep apnea (CSA) conditions if a complete facility-based, attended polysomnogram, performed prior to initiating therapy, documents all the following:

- The diagnosis of CSA
- The ruling out of a single-level device (CPAP) as effective therapy if either CSA or OSA is a component of sleep-associated hypoventilation
- Significant improvement of the sleep-associated hypoventilation with the use of a BiPAP device (with or without backup) on the settings that will be prescribed for initial use at home, while breathing the member’s usual FiO₂

Hypoventilation Syndrome

A BiPAP device **without backup** may be covered for members with hypoventilation syndrome if all the following criteria are met:

- An initial arterial blood gas PaCO₂, done while the member is awake and breathing the member’s prescribed FiO₂, is greater than or equal to 45 mm Hg.
- Spirometry shows an FEV1/FVC of greater than or equal to 70% and an FEV1 of greater than or equal to 50% of predicted.

- One of the following measurements has been demonstrated for the member:
 - An initial arterial blood gas PaCO₂, done during sleep or immediately upon awakening, and breathing the member's prescribed FiO₂, shows the member's PaCO₂ worsened greater than or equal to 7 mm Hg compared to the original result of the first requirement.
 - A facility-based polysomnogram demonstrates oxygen saturation of less than or equal to 88% for greater than or equal to 5 minutes of nocturnal recording time, not caused by obstructive upper-airway events.

A BiPAP device **with backup** may be covered if all the following criteria for members with hypoventilation syndrome are met:

- A covered BiPAP device without backup is being used.
- Spirometry shows an FEV₁/FVC of greater than or equal to 70% and an FEV₁ of greater than or equal to 50% of predicted.
- One of the following measurements has been demonstrated for the member:
 - An arterial blood gas PaCO₂, done while the member is awake and breathing the member's prescribed FiO₂, worsens greater than or equal to 7 mm Hg compared to the result performed to qualify the member for the BiPAP device without backup.
 - A facility-based polysomnogram, performed while the member is using the BiPAP device without backup, demonstrates oxygen saturation of less than or equal to 88% for greater than or equal to 5 minutes of nocturnal recording time, not caused by obstructive upper airway events.

Continued Coverage Beyond the First 3 Months of Therapy

Members covered for the first 3 months of using a BiPAP device (with or without backup) must be re-evaluated to establish the medical necessity of continued coverage by the IHCP. While the member may need to be evaluated at earlier intervals after the initiation of therapy, the re-evaluation upon which IHCP will base a decision to continue coverage beyond this time must occur within 61 to 90 days of initiating therapy.

For continued coverage beyond the first 3 months of therapy, the member's medical record must include documentation about the progress of relevant symptoms and the member's usage of the device up to that time. Failure of the member to consistently use the BiPAP device for an average of 4 hours per 24-hour period by the time of the reevaluation represents noncompliant utilization for the intended purposes and expected benefits of this therapy. This noncompliance constitutes reason for the IHCP to deny continued service as not medically necessary.

In addition, the device supplier must obtain documentation signed and dated by the treating physician no sooner than 61 days after initiating use of the device. This documentation must declare that the member is compliantly using the device an average of 4 hours per 24-hour period, and that the member is benefiting from its use.

Humidifiers Used with a Positive Pressure Airway Device

The IHCP covers a heated or nonheated humidifier for use with a BiPAP device or a CPAP system, when ordered by a physician, based on medical necessity, and subject to prior authorization.

The IHCP considers humidifiers for use with a BiPAP or CPAP system for reimbursement only when physician documentation supports the medical necessity of the humidifier. Documentation must indicate that the member suffers from nosebleeds, extreme dryness of the upper airways, or other conditions that interfere with compliance or use of the BiPAP or CPAP, and that the humidifier could improve this condition.

Heated and nonheated humidifiers are single-patient-use devices, categorized as inexpensive and routinely purchased items. As such, these devices are available to members **for purchase only**, except as described in the following situation. For members who are dually eligible (for Medicare and Traditional Medicaid), the IHCP does not pay for the purchase of nonheated or heated humidifiers. The IHCP covers rental, temporarily, of these items for Medicare and Medicare Replacement Plan crossover claims only.

The IHCP does not require a rental trial period before purchase of these items.

Standers

The IHCP provides reimbursement for standers considered medically necessary in noninstitutional settings.

Types of covered standers include:

- Prone
- Supine
- Vertical
- Multi-positional
- Sit-to-stand

The IHCP does not provide reimbursement for mobile standers (also known as *dynamic standers*), which have large, pneumatic wheels and allow self-propulsion in the standing position through larger areas. However, the IHCP may cover the mobility option as a reimbursable accessory for the sit-and-stand type stander, allowing the member limited mobility in a small area. See the [Additional Requirements for Sit-to-Stand Standers](#) subsection for coverage criteria.

Prior authorization for medical necessity is required for all standers covered by the IHCP. The PA request must specify the brand name, model number, type of stander, and base price of the stander. Certain types of standers require additional documentation, as described in the following sections.

An itemized list of any additional attachments and accessories with individual prices must be included with the PA request. Trays are included in the stander's base price; upgraded trays will not be reimbursed. Certain supports and straps are included in the stander's base price; upgraded supports and straps are considered on a case-by-case basis.

All initial and subsequent PA requests for standers must include a completed *Medical Clearance Form for Standing Equipment* (available on the [Forms](#) page at in.gov/medicaid/providers), signed by the physician who orders the stander.

All **initial** PA requests for standers require the following items:

- A completed medical clearance form signed by the physician
- A copy of a physical therapy and/or occupational therapy evaluation within the last 2 months, showing the patient's functional and cognitive baseline and ability to progress with therapy
- Documentation of medical necessity
- A plan of care (POC) signed by the ordering physician (see the [Plan of Care](#) section)

Subsequent PA requests for standers require the following items:

- A completed medical clearance form signed by the physician
- Ongoing documentation indicating progress toward goals through the 15th month or the final month

Plan of Care

The POC must include the following documentation:

- Measurable goals for therapy and training, therapy necessary to obtain a stander may be performed by a physical therapist, occupational therapist, or family member who has been properly trained to perform the necessary exercises
- Estimated amount of time the member is expected to stand:
 - The member should be able to stand 1 hour a day or have the potential goal of standing 1 hour a day.
 - The member is not required to stand for 1 hour continuously.
- List of expected benefits from utilizing the stander as an adjunctive therapy, which may include but are not limited to the following examples:
 - Aids in the prevention of atrophy in the trunk and leg muscles
 - Improves circulation to the trunk and lower extremities
 - Prevents formation of decubitus ulcers (pressure sores) with changeable positions
 - Helps maintain bone integrity
 - Reduces swelling in the lower extremities
 - Improves range of motion
 - Improves kidney and bladder function
 - Decreases muscle spasms
 - Strengthens the cardiovascular system and builds endurance
 - Improves strength of the trunk and lower extremities
 - Prevents or decreases muscle contractures
 - Lessens or prevents progressive scoliosis
 - Aids normal skeletal development
 - Improves bowel function

Additional Requirements for Multi-Positional Standers

When a multi-positional stander is requested, the provider must indicate the secondary complications that justify the need for a multi-positional stander. Secondary complications include but are not limited to the following examples:

- The member requires postural drainage.
- The member requires suctioning related to excessive secretions while in the stander.
- The member has a history of postural hypotension.

Additional documentation that must be included in the PA request for a multi-positional stander includes the following:

- Specific muscle groups targeted for stretching and strengthening in the stander and expected outcomes
- Specific orders indicating the proper positioning of the member in the stander

Additional Requirements for Sit-to-Stand Standers

All requests for sit-to-stand standers will be considered on a case-by-case basis. All diagnoses listed previously will be considered for sit-to-stand standers. The member must be able to perform the following:

- Maneuver from a sitting to a standing position without assistance
- Stand vertically or have the medical potential to stand vertically in the near future

Documentation of medical justification for a sit-to-stand stander must be included in the PA request. Some examples of secondary conditions that may justify the need for a sit-to-stand stander are as follows:

- Children who are not ready to stand fully upright, but are actively in transition between sitting and standing
- Highly independent youth and adults who can stand vertically and safely transfer alone
- Members who cannot stand for long periods of time due to contractures or muscle weakness
- Members with orthostatic hypotension

Children are not required to be independent to meet the criteria for sit-to-stand standers. Decisions regarding approval for children will be made on a case by case basis.

Certain sit-to-stand standers have a mobility option. The mobility option is identified by two medium sized all-terrain tires on the front of the stander and casters in the rear of the stander. Two maneuvering wheels are placed at waist level and attached to a pulley system which allows the member limited mobility in a small area. The IHCP will cover the mobility option as a reimbursable accessory. The mobility option will be approved only for members with independent capabilities and with the bilateral upper-body strength and coordination to maneuver themselves.

Transcutaneous Electrical Nerve Stimulator

All PA requests for the transcutaneous electrical nerve stimulator (TENS) unit must include a completed *Medical Clearance Form for TENS* (available on the [Forms](#) page at in.gov/medicaid/providers), signed by the physician who orders the TENS.

Trend Event Monitoring and Apnea Monitors

Providers should use HCPCS code E0618 when a member requires an apnea monitor without a recording feature. For trend event monitoring with an apnea monitor that has recording features, use HCPCS code E0619 for the actual monitor and the appropriate CPT code for monitoring, recording, transmission, and interpretation.

Wheelchairs

The IHCP provides reimbursement for nonmotorized (manual) wheelchairs, motorized (power) wheelchairs, power operated vehicles (POVs), and wheelchair accessories when medically necessary for IHCP members. Prior authorization is required, and certain medical criteria must be met for the approval of each piece of equipment.

IHCP reimbursement is limited to one nonmotorized wheelchair, motorized wheelchair, or POV per 5-year period, unless a change in the member's medical needs is documented in writing by the requesting provider. The change in medical needs must be significant enough to warrant a different type of equipment. Any wheelchair designated for use as a backup will be denied as not medically necessary.

Reimbursement for nonmotorized and motorized wheelchairs includes all labor charges involved in the assembly of the wheelchair. Reimbursement of nonmotorized wheelchairs, motorized wheelchairs, and POVs also includes emergency services, delivery, setup, and items covered under warranty.

Note: The IHCP includes standard nonmotorized wheelchairs in the per diem rate for LTC facilities, per 405 IAC 5-13-3-4 and 405 IAC 5-13-3-7. Providers can submit requests for prior authorization of a custom wheelchair for a member in an LTC facility only if there is a medical necessity for the custom wheelchair. For example, if the member's diagnosis requires sitting in a particular upright position due to a breathing difficulty, the member may need a customized wheelchair. Providers must follow the normal PA process, using IHCP medical clearance forms and the IHCP Prior Authorization Request Form, the Portal PA request, or 278 electronic transaction.

LTC members receive 24-hour care in a nursing facility. This care includes safety, propulsion, and evaluation of the member for skin breakdown, and following an active plan of care to prevent and treat decubitus ulcers. Therefore, providers should not request custom wheelchairs for the sole purpose of providing safety, preventing decubitus ulcers, allowing self-propulsion, or providing restraint.

Standing Wheelchairs

The IHCP does not cover standing wheelchairs, because there is insufficient clinical data to support the benefits of this equipment.

Nonmotorized Wheelchairs

The IHCP reimburses for both standard and nonstandard nonmotorized adult wheelchairs, and for nonmotorized pediatric wheelchairs, when medically necessary.

PA requests for nonmotorized wheelchairs must include a completed *Medical Clearance Form for Nonmotorized Wheelchair Purchase* (available for download from the [Forms](#) page at in.gov/medicaid/providers), signed by a physician. The medical clearance form must document the member's condition, mobility needs, and/or prognosis to support the medical necessity for a nonmotorized wheelchair.

Power Mobility Devices (PMDs)

Power mobility devices (PMDs) include motorized wheelchairs and POVs.

The IHCP covers PMDs only when the member is enrolled in a school, sheltered workshop, or work setting, or if the member is left alone for significant periods of time. Providers must document that the member can safely operate the device and that the member does not have the upper extremity function necessary to operate a nonmotorized wheelchair.

The following defined criteria must be met for a member to qualify for any PMD:

- The member must have significant mobility limitations that restrict his or her ability to complete one or more mobility-related activities of daily living (MRADLs), such as toileting, feeding, dressing, or bathing.
- The member's mobility issues are not resolved safely with the use of a cane or walker.

- The member is unable to use a properly fitted and functioning nonmotorized wheelchair in the home, at work, at school, or in the workshop to complete the MRADL for one or more of the following reasons:
 - Lack of upper body strength
 - Lack of coordination
 - Limited range of motion in upper body
 - Presence of pain that limits upper body mobility
 - Upper body physical deformity or amputations

PA requests for PDLs must include a completed *Medical Clearance Form for Motorized Wheelchair Purchase* (available for download from the [Forms](https://www.in.gov/medicaid/providers) page at [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers)), signed by a physician. The medical clearance form must document the medical necessity for a nonmotorized wheelchair.

Motorized Wheelchairs

Providers should determine the most appropriate HCPCS code to use for motorized wheelchairs, based on the Product Classification List published by the DME Pricing, Data Analysis, and Coding (PDAC) contractor for the CMS. This listing itemizes the manufacturers and specific motorized wheelchair models and details the exact HCPCS code associated with each product and model number.

A member who requires a motorized wheelchair is usually nonambulatory and has severe weakness of the upper extremities due to a neurologic or muscular disease or condition and would otherwise be confined to a bed or chair without the use of the motorized wheelchair. A motorized wheelchair is covered if the member's condition is such that the requirement for a motorized wheelchair is long-term (at least 6 months).

All IHCP members requesting a motorized wheelchair must meet the following criteria:

- The CMS-defined basic coverage criteria are met.
- The member does not qualify for a power operated vehicle (POV).
- The member is physically and mentally able to safely operate a motorized wheelchair or has a caregiver who is unable to adequately propel an optimally configured nonmotorized wheelchair, but is available and willing to operate the motorized wheelchair for the member.
- The home environment allows appropriate access with a motorized wheelchair, including maneuvering space and appropriate surfaces.
- The member does not exceed the weight limitations for the motorized wheelchair provided.
- A motorized wheelchair will significantly improve the member's ability to independently perform MRADLs.
- The member is willing to use a motorized wheelchair.
- The member is enrolled in a school, sheltered workshop, or work setting, or the member is left alone for a significant period of time.

Providers cannot bill separately for programmable electronic systems that come standard on the specific motorized wheelchair model provided, as the total reimbursement for the motorized wheelchair with programmable electronics is an all-inclusive rate. The IHCP allows separate reimbursement only if an electronic system is an upgrade to a system that comes standard on a specific wheelchair model, and only when the upgrade is medically necessary. Any such upgrades must have PA.

Certain patients may need adaptive switch controls (such as a sip-and-puff controls), and patients with degenerative diseases whose prognosis could worsen in the future may need additional drive controls and programming not available on the basic one-drive electronic system. The medical necessity supporting the need for a programmable electronic system upgrade must be included on the *Medical Clearance Form for Motorized Wheelchair Purchase*.

The following accessories and options are considered to be included in the basic equipment package for motorized wheelchairs (any exceptions must be submitted for PA consideration at the time of the wheelchair is purchased or rented):

- Lap belt or safety belt
- Battery charger
- A complete set of tires and casters, any type
- Leg rests
- Leg rest/leg rest platform
- Arm rest
- Weight specific components, such as braces, bars, upholstery, brackets, motors, or gears, mandated by additional patient weight
- Any seat width and depth
- Any back width
- Controller and input devices for non-expandable and standard proportional joystick

The following services are allowed outside the basic equipment package for all motorized wheelchairs in **groups 1 through 5**, with PA and only if medical necessity criteria are met. Any services billed outside the basic equipment package must be submitted on the same claim for the same date of service:

- Adjustable height arm rests
- Shoulder harness/straps or chest/straps/vest
- Elevating leg rests
- An expandable controller
- Nonstandard joystick, that is, non-proportional or mini, compact, or short throw proportional

Similarly, the following services are allowed outside the basic equipment package for all motorized wheelchairs in **groups 3, 4, and 5**, with PA and only if medical necessity criteria are met. Any services billed outside the basic equipment package must be submitted on the same day claim for the same date of service:

- Angle adjustable foot plates
- Motorized wheelchairs with a sling/solid seat/back:
 - Standard duty, seat width and/or depth greater than 20 inches
 - Heavy duty, seat width and/or depth greater than 22 inches
 - Very heavy duty, seat width and/or depth greater than 24 inches
- Motorized wheelchairs with a sling/solid seat/back:
 - Standard duty, back width greater than 20 inches
 - Heavy duty, back width greater than 22 inches
 - Very heavy duty, back width greater than 24 inches
- Nonstandard seat and back will only be provided if the IHCP member's physical dimensions are provided and require the additional seat width and depth. PA and medical necessity criteria are required.

Motorized Wheelchairs – Single-Power Option

For **groups 2 and 5** single-power-option motorized wheelchairs, **one** of the following additional criteria must apply:

- The member requires a drive control interface other than a hand or chin operated standard proportional joystick (such as head control, sip and puff, switch control, and so forth)
- The member meets the requirements for a power tilt or power recline seating system, and the system is being used on the wheelchair.

For **groups 3 and 4** single-power-option motorized wheelchairs, the following additional criteria apply:

- The member has mobility limitations due to a neurological condition, myopathy, or congenital skeletal deformity.
- And **one** of the following additional criteria:
 - The member requires a drive control interface other than a hand or chin operated standard proportional joystick (such as, head control, sip and puff, switch control, and so forth).
 - The member meets the requirements for a power tilt or power recline seating system, and the system is being used on the wheelchair.

Motorized Wheelchairs – Multiple Power Option

Groups 2 and 5 multiple-power-option motorized wheelchairs require any **two** of the follow three criteria:

- The member uses a ventilator that is mounted to the wheelchair.
- The member requires a drive control interface other than a hand or chin operated standard proportional joystick (such as, head control, sip and puff, switch control, and so forth)
- The member meets the requirements for a power tilt or power recline seating system and the system is being used on the wheelchair.

For **groups 3 and 4** multiple-power-option motorized wheelchairs, the following criteria apply:

- The member has mobility limitations due to a neurological condition, myopathy, or congenital skeletal deformity.
- And any **two** of the following three criteria:
 - The member uses a ventilator that is mounted to the wheelchair.
 - The member requires a drive control interface other than a hand or chin operated standard proportional joystick (such as, head control, sip and puff, switch control, and so forth)
 - The member meets the requirements for a power tilt or power recline seating system and the system is being used on the wheelchair.

Motorized Wheelchairs – No Power Option

For no-power option **groups 3 and 4** motorized wheelchairs, the IHCP member must have mobility limitations due to a neurological condition, myopathy or congenital skeletal deformity.

Power-Operated Vehicles

The IHCP will reimburse for a POV, such as scooters, for members who are unable to operate nonmotorized wheelchairs and who have adequate trunk stability to safely operate the vehicle. A POV should be considered when the member does not require the full support or features that are provided by power wheelchairs. POVs are not covered by the IHCP when they are needed for use outside the home only, or to allow the member to perform leisure or recreational activities. Therefore, POVs that are designed, by size and features, primarily for outdoor use, will be denied as not medically necessary.

The prior authorization criteria for all POVs are as follows:

- The CMS defined basic coverage criteria are met.
- The member has the ability to safely transfer to and from the POV.
- The member has the ability to operate the tiller-steering system.
- The member has the ability to maintain proper body position and stability while operating the POV.
- The member has the physical and mental capability to safely operate a POV.
- The home environment allows appropriate access with a POV, including maneuvering space and appropriate surfaces.
- The patient does not exceed the weight limitations for the POV provided.
- A POV will significantly improve the IHCP member's ability to independently perform MRADL.
- All accessories and options for a POV are included in the initial reimbursement rate of the POV, including but not limited to the following:
 - Lap or safety belt
 - Battery or batteries required for operation
 - Battery charger, single mode
 - Complete set of tires
 - Weight appropriate upholstery and seating system
 - Tiller steering
 - Non-expandable controller with proportional response to input
 - All accessories needed for the safe operation of the POV

A completed *Medical Clearance Form Motorized Wheelchair Purchase* must be submitted with the PA request form that documents the member's condition, mobility needs, and/or prognosis to support the medical necessity for a POV. Documentation must indicate the member's condition that renders them unable to operate a nonmotorized wheelchair. Documentation must also indicate the member is capable of safely operating a POV, can transfer in and out of a POV, and has adequate trunk stability to safely ride in and operate the POV.

Wheelchair Accessories – Universal Headrest Plate

Providers must use HCPCS code E1028 – *Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory* for PA and billing for universal headrest plates.

The IHCP denies requests for approval of the universal headrest plate using HCPCS code E1399 – *Durable medical equipment, miscellaneous*. Providers should submit their usual and customary charge using HCPCS code E1028.

Reimbursement of universal headrest plates are subject to the following PA criteria:

- The IHCP covers universal headrest plates when the initial headrest ordered for a new wheelchair does not meet the member's needs upon the first or subsequent fittings.
- The IHCP covers universal headrest plates for a used wheelchair if the member's condition changes and the wheelchair back is not predrilled for the headrest. The provider must provide documentation of the medical necessity for the headrest.
- The IHCP covers replacement universal headrest plates with documentation of an explanation for the replacement (for example, the plate is damaged due to high tone or spasticity of the patient).

On the PA request, the provider must document the brand name and model of the original headrest, and include an explanation of why the headrest did not meet the member's needs. In addition, the provider must indicate the brand name and model of the subsequent headrest that will be used on the wheelchair.

The IHCP does not cover universal headrest plates for the initial headrest ordered for use on a new wheelchair. The wheelchair back should be predrilled to accommodate the headrest initially ordered with the wheelchair.

Wheelchair Accessories – Elevating Leg Rests

The IHCP covers elevated leg rests if the member meets the following criteria:

- Documentation of musculoskeletal condition or the presence of a cast or brace which prevents 90° flexion at the knee
- Documentation of significant edema of the lower extremities
- Evidence that the member meets the criteria for and has a reclining back on the wheelchair

The provider must provide documentation that the member meets the preceding criteria.

Wheelchair Accessories – Power Tilt and/or Recline Seating System

All three of the following criteria must be met to be reimbursed for a power tilt or recline seating system, or the combination of a power tilt and recline seating system:

- The member must qualify for a power wheelchair that accommodates a power tilt and/or recline seating system.
- The member had an evaluation that was performed by a licensed/certified medical professional, such as a physical or occupational therapist, or a physician who has specific training and experience in rehabilitation wheelchair evaluations. These professionals must document the medical necessity for the device and its special features in the patient's home, work, school, or workshop. The physical or occupational therapist or physician may have no financial relationship with the supplier.
- The provider must substantiate and document that the member meets one of the following in addition to the preceding two criteria:
 - The member is unable to perform a functional weight shift and is therefore at high risk of developing pressure ulcers.
 - The member uses intermittent catheterization for bladder management and is unable to transfer independently from the wheelchair to the bed.
 - The seating system will be used to manage increased tone and spasticity.